

**APPLICATION FACE SHEET FOR FY 2005
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**

STATE NAME: Nebraska
DUNS #: 808819957 (Nebraska Department of Health and Human Services)

I. AGENCY TO RECEIVE GRANT

AGENCY: Nebraska Department of Health and Human Services
ORGANIZATIONAL UNIT: Office of Mental Health, Substance Abuse and Addiction Services
STREET ADDRESS: PO Box 98925
CITY: Lincoln State: NE ZIP CODE: 68509-8925
TELEPHONE: (402) 479-5125 FAX: (402) 479-5162

**II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR
ADMINISTRATION OF CMHS BLOCK GRANT**

NAME: Nancy Montanez TITLE: Director
AGENCY: Nebraska Department of Health and Human Services
ORGANIZATIONAL UNIT: _____
STREET ADDRESS: P.O. Box 95044
CITY: Lincoln State: NE ZIP CODE: 68509- 5044
TELEPHONE: (402) 471-9106 FAX: (402) 471-0820

III. STATE FISCAL YEAR

FROM: July 2004 TO: June 2005

**IV. PERSON TO CONTACT WITH ANY QUESTIONS REGARDING THE
APPLICATION**

NAME: James S. Harvey, LCSW TITLE: Quality Improvement Coordinator
AGENCY: Nebraska Department of Health and Human Services
ORGANIZATIONAL UNIT: Division of Behavioral Health Services
Office of Mental Health, Substance Abuse and Addiction Services
STREET ADDRESS: PO Box 98925
CITY: Lincoln State: NE ZIP CODE: 68509-8925
TELEPHONE: (402) 479-5125 FAX: (402) 479-5162 EMAIL: jim.harvey@hhss.state.ne.us

EXECUTIVE SUMMARY

This application was prepared to reflect the current statewide changes impacting the mental health system in Nebraska. There are some major changes underway in Nebraska at this time. In his "State of the State Address" on January 15, 2004, Governor Mike Johanns said one of his five goals for the legislative session was mental health reform. Regarding the care of adults with mental illness, the Governor said, "We have a compelling moral responsibility to see that these individuals are cared for in the least restrictive environment". Referring to LB1083, the Governor said, "The legislation before you is the right thing to do. It commits us to a course of recovery for these citizens in their communities, near their support systems".

The "Nebraska Behavioral Health Services Act" (LB 1083) was passed by the Legislature on a vote of 44 – 2 and signed by the Governor on April 14, 2004. LB1083 represents a major reform of the Nebraska Behavioral Health System by revising the framework for the provision of behavioral health services in Nebraska.. LB1083 Section 4.(2) defines a "Behavioral Health disorder" as "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder". The intent of the Behavioral Health Reform is to focus on the areas of state leadership, regional administration, statewide advocacy, funding, and legislative oversight. It requires planning for the statewide development of community-based behavioral health services and reduction in the necessity and demand for regional center services.

Under LB1083 Section 5 (1) The Division of Behavioral Health Services is established within the Nebraska Department of Health and Human Services. LB1083 Section 6 (1) says the Division shall act as the chief Behavioral Health authority for the State of Nebraska. The Office of Mental Health, Substance Abuse and Addiction Services is located within the Division of Behavioral Health Services. HHS contracts with the six Regional Behavioral Health Authorities established under LB1083 Sections 7-9 to purchase community mental health services.

On July 1, 2004, the Behavioral Health Implementation Plan was submitted to the Governor, Legislature, and the Behavioral Health Oversight Commission of the Legislature (per LB1083 section Section 18). This plan will be guiding the future of the behavioral health system within Nebraska for years to come. Core Principles of Behavioral Health Reform

- Consumers will have services that better meet their needs and are closer to their families and communities
- Community services must be in place before patients are transitioned
- Acute and Secure hospital levels of care will continue to be required
- Current funding will be leveraged with Medicaid match dollars and re-invested in the appropriate community services
- Reform will happen in incremental steps

The Maintenance of Effort Actual/Estimated for 2004 was \$31,207,611. The final FY2004 Community Mental Health Block Grant allocation was \$2,105,983. Using these figures, the Federal Community Mental Health Services Block Grant represents 6.7% of the estimated 2004 state expenditures for Mental Health Services in Nebraska, including the Medicaid Rehabilitation Option match and excluding all other Medicaid Behavioral Health funds.

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Ms. Lou Ellen M. Rice
Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

On behalf of the State of Nebraska, I hereby authorize the Director of the Department of Health and Human Services to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant.

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the Community Mental Health Block Grant to:

Nancy Montanez, Director
Department of Health and Human Services
PO Box 95044
Lincoln, NE 68509-5044

Thank you for your attention to this matter

Sincerely,

Mike Johanns, Governor

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August 27, 2004

Ms. LouEllen M. Rice
Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

Effective immediately and until further notice, please send the NOTICE OF BLOCK GRANT AWARD concerning the Community Mental Health Block Grant to:

Ronald E. Sorensen, Office Administrator
Division of Behavioral Health Services
Office of Mental Health, Substance Abuse and Addiction Services
Nebraska Department of Health and Human Services
P.O. Box 98925
Lincoln, NE 68509-8925

Thank you for your attention to this matter

Sincerely,

Nancy Montanez, Director
Nebraska Department of Health and Human Services

Cc: Richard DiGeronimo, State Planning and Systems Development Branch
Center for Mental Health Services
U.S. Department of Health and Human Services

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Federal Requirements

PART B. Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance

- I. Set-Aside for Children's Mental Health Services Report
- II. Maintenance of Effort Report (MOE)

Set-Aside for Children's Mental Health Services

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Children's Services			
Calculated 1994	Actual 2002	Actual 2003	Actual/Estimated 2004 *
\$620,801	\$3,793,391	\$3,872,010	\$4,332,646

***NOTE:** (1) An additional \$1,096,962 was carried over and expended from a CMHS special children's grant by November 30, 2003. (2) Local contractors have the flexibility to contract per the local priorities and needs in adult and children's services; therefore, the amount of funds contacted may fluctuate between adults and children's services annually. (3) Revised billings were approved for June 2003 in August 2003, therefore, the actual for FY03 will change when the payments have cleared the system.

Maintenance of Effort (MOE)

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Mental Health Services		
Actual 2002	Actual 2003	Actual/Estimated 2004
\$24,015,746	\$29,036,852	\$31,207,611

***NOTE:** Local contractors have the flexibility to contract per the local priorities and needs in adult and children's services; therefore, the amount of funds contacted may fluctuate between adults and children's services annually.

FISCAL PLANNING ASSUMPTIONS

Federal Requirements

This section covers both Adult and Children Services

PART B. Fiscal Planning Assumptions

- Intended use of the funds based on amount of allocation made to the State for the prior FY.
- Funds awarded under this Block Grant are available for obligation and expenditure for the full two-year period. For the FY 2005 block grant award, the period is 10/1/04 – 9/30/ 2006.
... and ...

Criterion 5 - Describes financial resources, staffing and training for mental health services providers necessary for the plan

- Describes financial resources
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

SECTION III – STATE PLAN**A. Fiscal Planning Assumptions for Adults and Children**

In Nebraska, the fiscal planning assumption for the Community Mental Health Services Block Grant is based on the final allocation from FY2004 = \$2,105,983. This year, the Mental Health aid being reported includes the Federal Mental Health Block Grant, state General Funds and tobacco settlement funds designated for behavioral health services, expended or allocated to community mental health. The Federal Community Mental Health Services Block Grant represents 6.7% of the estimated 2004 state expenditures for Mental Health Services in Nebraska, including the Medicaid Rehabilitation Option match and excluding all other Medicaid Behavioral Health funds.

FY2005 Mental Health Block Grant Funds / TOTAL FUNDS BY TARGET POPULATION

	CMHS Block Grant	%
Adult Residential, Rehab, and Support Services	\$490,495	23.3%
Adult Treatment Services	\$598,820	28.4%
Total Services for SPMI/SMI Adults	\$1,089,315	51.7%
Services for SED Children/Youth	\$847,465	40.2%
Rural Service Equity +	\$63,904	3.1%
State Administration (5%)	\$105,299	5.0%
FY2004 TOTAL FUNDS (100 %)	\$2,105,983	100.0%

+Rural Service Equity funds are allocated as needed to rural areas.

The State mental health funds are used to match federal Vocational Rehabilitation funds through the Nebraska Department of Education Division of Vocational Rehab per a State Cooperative Agreement. In FY2004, \$279,668 State funds match approximately \$1,319,000 federal VR funds on a 21% State to 79% federal match rate to serve persons with mental illness in vocational rehabilitation services.

**TABLE 1: FY2005 FEDERAL MENTAL HEALTH BLOCK GRANT FUNDS (Rev 8/25/04)
FOR COMMUNITY MENTAL HEALTH SERVICES (CONTRACTED WITH REGIONS)**

		REGIONS						
		1	2	3	4	5	6	TOTALS
SERVICES								
Adult Residential, Rehab, and Support Services	** Community Support - MH		\$ 75,258	\$ 15,240	\$ 34,829		\$ 8,825	\$ 134,152
	** Day Rehabilitation		\$ 57,033				\$ 22,176	\$ 79,209
	** Psych Residential Rehab						\$ 131,400	\$ 131,400
	Vocational Support	\$ 1,440		\$ 15,534	\$ 38,800			\$ 55,774
	Day Support	\$ 33,360		\$ 41,600				\$ 74,960
	Dual Residential (SPMI/CD)					\$ 15,000		\$ 15,000
<i>Subtotal</i>		\$ 34,800	\$ 132,291	\$ 72,374	\$ 73,629	\$ 15,000	\$ 162,401	\$ 490,495

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Adult Treatment Services	Day Treatment					\$ 20,000		\$ 20,000
	Assessment Only - MH						\$30,000	\$30,000
	OP Assessment & Therapy - MH	\$ 29,419		\$ 43,134	\$ 35,066	\$ 144,000	\$ 145,827	\$ 397,446
	OP Assessment & Therapy - Dual			\$ 8,928				\$ 8,928
	Medication Management	\$ 6,032	\$ 40,504	\$ 50,910			\$ 45,000	\$ 142,446
	<i>Subtotal</i>	\$ 35,451	\$ 40,504	\$ 102,972	\$ 35,066	\$ 164,000	\$ 220,827	\$ 598,820
Children's Services	C/Y Day Treatment	\$ 38,000		\$ 42,856				\$ 80,856
	C/Y Therapeutic Consult (School)		\$ 15,000			\$ 73,000		\$ 88,000
	C/Y Professional Partner			\$ 50,000	\$ 80,000	\$ 150,921	\$ 200,000	\$ 480,921
	C/Y Prof Partner/School Wraparound	\$ 78,000			\$ 83,850			\$ 161,850
	C/Y Intensive Outpatient					\$ 35,838		\$ 35,838
	<i>Subtotal</i>	\$ 116,000	\$ 15,000	\$ 92,856	\$ 163,850	\$ 259,759	\$ 200,000	\$ 847,465
	REGION BLK GRT FUND TOTALS	\$ 186,251	\$ 187,795	\$ 268,202	\$ 272,545	\$ 438,759	\$ 583,228	\$ 1,936,780

** Serving non Medicaid eligible consumers

TABLE 2: FY2005 COMMUNITY MENTAL HEALTH FUNDING (ALL FUND SOURCES)

FUNDING SOURCE	State General \$	Tobacco Rate \$	Tobacco New/Exp \$	Tobacco Psych Emerg \$	Fed Blk Grt \$	Other Fed \$	BH/MRO \$	TOTAL \$
REGIONAL CONTRACTS		Tobacco Settlement Cash Funds						
1	\$1,150,331	\$98,914	\$114,200	\$48,898	\$186,251	\$0	\$514,050	\$2,112,644
2	\$1,069,164	\$76,105	\$334,041	\$48,153	\$187,795	\$0	\$137,045	\$1,852,303
3	\$2,882,753	\$217,928	\$0	\$109,818	\$268,202	\$0	\$507,989	\$3,986,690
4	\$2,295,898	\$221,549	\$175,185	\$113,304	\$272,545	\$0	\$921,198	\$3,999,679
5	\$4,359,144	\$323,955	\$444,033	\$525,797	\$438,759	\$0	\$896,109	\$6,987,797
6	\$8,565,026	\$750,539	\$1,711,756	\$654,030	\$583,228	\$0	\$1,021,168	\$13,285,747
<i>SUBTOTAL REGIONAL \$</i>	\$20,322,316	\$1,688,990	\$2,779,215	\$1,500,000	\$1,936,780	\$0	\$3,997,559	\$32,224,860
OTHER STATE								

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CONTRACTS								
Native American - Omaha Tribe	\$207,498	\$0	\$0	\$0	\$0	\$0	\$0	\$207,498
Native American - Ponca Tribe	\$67,729	\$0	\$0	\$0	\$0	\$0	\$0	\$67,729
Native American - Santee Sioux Tribe	\$70,033	\$0	\$0	\$0	\$0	\$0	\$0	\$70,033
Native American – Winnebago Tribe	\$143,990	\$0	\$0	\$0	\$0	\$0	\$0	\$143,990
PATH MH Homeless Services Grant	\$0	\$0	\$0	\$0	\$0	\$288,000	\$0	\$288,000
ASO/Managed Care Contract	\$1,482,254	\$0	\$0	\$0	\$0	\$0	\$0	\$1,482,254
Women's BH Coalition	\$54,000	\$0	\$0	\$0	\$0	\$0	\$0	\$54,000
Consumer / Family Org Projects	\$135,500	\$0	\$0	\$0	\$0	\$0	\$0	\$135,500
Indigent Medications	\$2,000,000	\$0	\$0	\$0	\$0	\$0	\$0	\$2,000,000
Rural MH Crisis Counseling Voucher Services	\$100,000	\$0	\$0	\$0	\$0	\$0	\$0	\$100,000
MH Statewide Training	\$61,242	\$0	\$0	\$0	\$0	\$0	\$0	\$61,242
<i>SUBTOTAL OTHER Funds</i>	\$4,322,246	\$0	\$0	\$0	\$0	\$288,000	\$0	\$4,610,246
Unallocated/Cash Flow/Rural Service Equity					\$63,904			\$63,904
State Administration (5% BlkGrt)					\$105,299			\$105,299
<i>TOTAL \$</i>	\$24,644,562	\$1,688,990	\$2,779,215	\$1,500,000	\$2,105,983	\$288,000	\$3,997,559	\$37,004,309

Federal Requirements

PART B. Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance

III. State Mental Health Planning Council Requirements

- a) Membership Requirements
- b) State Mental Health Planning Council Membership List and Composition
- c) Planning Council Charge, Role and Activities
- d) State Mental Health Planning Council Comments and Recommendations

MENTAL HEALTH PLANNING COUNCIL

The Nebraska Behavioral Health Services Act (LB 1083) was approved by the Governor on April 14, 2004. Under LB1083 Section 14 the State Advisory Committee on Mental Health Services is established. Section 14 (2) (a) says the committee shall serve as the State's mental

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health planning Council as required by Public Law 102-321. The state statute authorizing the former NE Mental Health Planning and Evaluation Council was repealed under LB1083 (149).

- State Mental Health Planning Council Membership List and Composition

The Governor appoints the membership of the State Advisory Committee on Mental Health Services. Here are the appointments as of July 16, 2004:

TABLE 1. List of Planning Council Members

	NAME	TYPE OF MEMBERSHIP	AGENCY OR ORGANIZATION	ADDRESS, PHONE & FAX
Consumers				
1	Wayne Adamson	Adult with Serious Mental Illness	Consumer / Region 3	1363 W. "E" Apt. #4 Hastings, NE 68901-5869 402-463-0532
2	Jimmy Burke	Adult with Serious Mental Illness	Consumer / Region 5	4603 Prescott Ave. Lincoln, NE 68506 402-483-4086
3	Richard Ellis	Adult with Serious Mental Illness	Consumer / Region 5	4123 Pace Blvd Lincoln, NE 68502 402-420-7415
4	Wesley Legan	Adult with Serious Mental Illness	Consumer / Region 6	616 N. 46th Street Apt. #5 Omaha, NE 68132 402-556-3702
5	Darlene Richards	Adult with Serious Mental Illness	Consumer / Region 1	310 W. 5th Bridgeport, NE 69336 308-262-2950
6	VACANT	Adult with Serious Mental Illness	Consumer / Region	
Family Members of Children with SED				
7	Dwain Fowler	Family Members of Children with SED	Family Child w/ SED / Region 3	P.O. Box 95 Franklin, NE 68939 308-425-3134
8	Clint Hawkins	Family Members of Children with SED	Family Child w/ SED / Region 4	P.O. Box 722 Woodlake, NE 69221 402-967-3012
9	VACANT	Family Member of Child with SED	Family Child w/ SED / Region	
Family Members of Adults with SMI				

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10	Nancy Kratky	Family Members of Adults with SMI	Family Adult w/ SMI / Region 6	1204 N. 101 Circle Omaha, NE 68114 402-390-0956
11	Susan Krome	Family Members of Adults with SMI	Family Adult w/ SMI / Region 5	7704 Ringneck Drive Lincoln, NE 68506 402-484-8653
12	Mary Wells	Family Members of Adults with SMI	Family Adult w/ SMI / Region 3	HC 71, Box 114-A Anselmo, NE 68813 308-749-2675
Other Representatives				
13	James Deaver	regional governing board member	Regional Behavioral Health Authority	32290 Road 751 Imperial, NE 69033 308-352-4000
14	Beth Baxter	regional administrator	Regional Behavioral Health Authority	Region 3 Mental Health & Substance Abuse Admin. 4009 6 th Ave., Suite 65 Kearney, NE 68848-2555 308-237-5113, Ext. 222
15	Allen Bartels	Provider of behavioral health services	Provider	603 N. Harvard Ave. Harvard, NE 68944 402-772-8291
16	Dr. Maria Prendes-Intel	provider of behavioral health services	Provider	633 Eastridge Drive Lincoln, NE 68510 402-483-1116
17	Beth Wierda	State Department of Education	State Employee	Department of Education Special Education P.O. Box 94987 NSOB 6 th Floor Lincoln, NE 68509-4987 402-471-2471
18	Frank Lloyd	Division of Vocational Rehabilitation	State Employee	4409 Browning Place Lincoln, NE 68516 402 420-2202
19	VACANT - Division of B H Services Admin.	HHS Mental Health	State Employee	
20	Chris Hanus	HHS social services	State Employee	HHSS/Protection & Safety 301 Centennial Mall South NSOB 3rd Floor Lincoln, NE 68509

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21	Cec Brady	HHS Medicaid	State Employee	HHS/F&S/Medicaid 301 Centennial Mall South NSOB 5th Floor Lincoln, NE 68509
22	Scott Ford**	NE Comm on Law Enforcement and Criminal Justice	Other (not state employees or providers)	1505 "G" Street - Police Department South Sioux City, NE 68776 402-494-7555
23	Lara Huskey	Housing Office Dept of Economic Development	State Employee	P.O. Box 94666 NSOB 6 th Floor Lincoln, NE 68509 402-471-3759

* Melia Cooke, an Adult with Serious Mental Illness, was appointed to serve as a Consumer representative State Advisory Committee on Mental Health Services. In August, prior to the first meeting, Ms. Cooke resigned from the Committee after being hired by Senator Jim Jensen to provide staff support to the Behavioral Health Oversight Commission of the Legislature.

** Mr. Ford is the Chief of Police in South Sioux City, NE

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	23	100%
Consumers/Survivors/Ex-patients (C/S/X)	5	
Family Members of Children with SED	2	
Family Members of Adults with SMI	3	
Vacancies (C/S/X & family members)	2	
Others (not state employees or providers)	1	
TOTAL C/S/X, Family Members & Others	13	57%
State Employees	5	
Providers / Regional Behavioral Health Authority	4	
Vacancies	1	
TOTAL State Employees & Providers	10	43%

MENTAL HEALTH PLANNING COUNCIL

- Membership Requirements
- Planning Council Charge, Role

The membership requirements as well as Planning Council Charge / Role are specified within LB1083 Section 14. (1).

Section 14. (1) The *State Advisory Committee on Mental Health Services* is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows:

- (a) One Regional Governing Board member,
 - (b) one Regional Administrator,
 - (c) twelve consumers of Behavioral Health services or their family members,
 - (d) two providers of Behavioral Health services,
 - (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education,
 - (f) three representatives from the Nebraska Health and Human Services System representing mental health, social services, and Medicaid,
 - (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and
 - (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.
- (2) The committee shall be responsible to the State Behavioral Health Council and shall
- (a) serve as the State's mental health planning Council as required by Public Law 102-321,
 - (b) conduct regular meetings,
 - (c) provide advice and assistance to the Council and the Division relating to the provision of mental health services in the State of Nebraska,
 - (d) promote the interests of consumers and their families,
 - (e) provide reports as requested by the Council or the Division, and
 - (f) engage in such other activities as directed or authorized by the Council.

MENTAL HEALTH PLANNING COUNCIL

- Activities

The state statute authorizing the former Nebraska Mental Health Planning and Evaluation Council (MHPEC) was repealed under LB1083 (149). The former MHPEC did meet on August 8, 2003; November 18, 2003; February 12, 2004 and June 17, 2004. At those meetings, the MHPEC did engage in its state and federal required duties.

The Nebraska Behavioral Health Services Act (LB 1083) was approved by the Governor on April 14, 2004. Under LB1083 Section 14 the State Advisory Committee on Mental Health Services was established.

The first official meeting of the State Advisory Committee on Mental Health Services was held on August 19th, 2004 at the Country Inn and Suites in Lincoln, Nebraska. The following State Advisory Committee on Mental Health Services Members present at the start of the meeting were Wayne Adamson, Beth Baxter, Cec Brady, Jimmy Burke, James Deaver, Richard Ellis, Scott Ford, Dwain Fowler, Chris Hanus, Clint Hawkins, Lara Huskey, Nancy Kratky, Susuan

Krome, Wesley Legan, Dr. Maria Prendes-Intel, Frank Lloyd, Darlene Richards, and Beth Wierda. Richard Ellis was elected as the Interim Chair of the Committee.

Federal Requirements

MENTAL HEALTH PLANNING COUNCIL

- State Mental Health Planning Council Comments and Recommendations

Below represents a record of the comments received from the public and members of the State Advisory Committee on Mental Health Services on August 19th, 2004.

PUBLIC COMMENT ON THE ADULT & CHILD/ADOLESCENT PLANS

J. Rock Johnson:

- ✓ Require more time on the agenda for the Federal Mental Health Block Grant Review
- ✓ Need to make material more available to the public
- ✓ Separate the state duties of the committee under LB1083 from the Federal Planning Council duties ... – separate and distinct federal and state functions.
- ✓ Put an E-mail list together of all committee members so the Committee could be e-mailed the revised Mental Health Block Grant before sending it in the Federal Government.
- ✓ The Committee meetings should be taped.
- ✓ fiscal planning assumptions - what could be important than how money will be spent. Would like to see increase spending on peer specialists. What are VR funds being spent on?
- ✓ regarding the flow of consumers, you need to show alternatives other than inpatient. Lack of step down services, i.e. need diversion from inpatient alternatives.
- ✓ Send out Committee Meeting Notices using the Consumer Mailing List in the Consumer Liaison's Office .
- ✓ Nebraska Recovery Network – Need more information.
- ✓ Committee get involved and provide input on service definitions
- ✓ The service definitions used should be reviewed and approved by this committee after consumer input has been received.
- ✓ Include Centers for Independent Living as a resource.
- ✓ Alternative Formats
- ✓ Mention Veterans, Native American services, etc.
- ✓ The State Behavioral Health Implementation Plan should be sent to the committee.
- ✓ Under served and unserved people with psychiatric disabilities will be given priority in an application prepared by the Independent Living Council.
- ✓ J. Rock wanted the Committee to watch the Federal Center for Mental Health Services video tape titled, "State Mental Health Planning and Advisory Councils: New Perspective" (total time 15 minutes; 7-21-00). However, Richard Ellis, Committee Interim Chair, ruled showing the video was out of order. The committee agreed that watching the videotape was not the purpose of the meeting. The only agenda item for the day's meeting was to review the Mental Health Block Grant. J. Rock then distributed a copy of the tape to members of the committee.

Cindy Scott:

- ✓ Children's Plan - Page 18 – asked a question to clarify in the Families Unite

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- ✓ Page 28 – Region 3 Grant - language of fully integrated system – problem with this language as it is not really a fully integrated system yet

Pat Talbot:

- ✓ Appreciate work of all on preparing the Mental Health Block Grant. However, there was not enough time to review the Block Grant.
- ✓ Too many gaps in the information in the Mental Health Block Grant – Data not available.
- ✓ Need to have adequate notice of meeting and published agenda, i.e. more notices about meeting – flyers, newsletter, etc.
- ✓ Consider the gaps in Transportation for consumers.

STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES RECOMMENDATIONS ON MH BLOCK GRANT APPLICATION;

Adult Plan

- ✓ Make access easier for the public to provide comments on the Mental Health Block Grant. To accomplish this, consider (1) the use of video conference for the review of block grant and (2) Use the six Regional Behavioral Health Authority Advisory Committees as part of the review process. These regional committees can put on forums and generate comments.
- ✓ Limitations of the current capacity on data systems is reason why Medicaid consumers are not included.
- ✓ Suicide prevention ... no additional funding is available. Core module has no funding. At this time it is an all volunteer effort. Looking for funding from SAMHSA.
- ✓ How will the Gap on Cultural Competence be addressed? Culturally competency is something that needs to be integrated into everything done. It is noted that culturally appropriate services are being specifically addressed by the University of Nebraska Public Policy Center's NEBHANDS project (www.nebhands.nebraska.edu). This grant is funded by the U.S. Department of Health and Human Services under the Capital Compassion Fund.
- ✓ Page 29 – regarding the flow of consumers, show outpatient as an alternative to inpatient.
- ✓ Low confidence in data ... Can we be confident in how we are measuring each regions statistics – data system problems
- ✓ Suicide Prevention Initiative – If no additional dollars – address how to go about continuing the Suicide Prevention Initiative. There may be money coming from the Feds for the Suicide Prevention Initiative. Need core module dollars. Use Federal Suicide Prevention dollars for Core Module.
- ✓ Is the Suicide Prevention work being coordinated with the Lancaster County Community Mental Health Center?
- ✓ Also, people with a shared vision can make things happen without the money.
- ✓ Page 82 – Under Crisis Centers – the holding facility has 36 hours
- ✓ Need to include more about the public participation in the Behavioral Health Reform
- ✓ Need longer timeline to review Mental Health Block Grant

Childrens' Plan

- ✓ Send out notices on this plan via the special education network.

- ✓ Do not see things connecting very well between Behavioral Health, Protection and Safety and Medicaid. We are doing things that are not reflected in the plan.
- ✓ Need to connect with schools on the transition youth ... Vocational Rehabilitation's role.
- ✓ Principles need to include families as decision makers at all levels and need to be outcome based.
- ✓ Adolescents in transition - Age Waiver Program – Number of kids served – Gap #2. ESU's have responsibility to youth in transition.
- ✓ Need to include the definition of SED youth.
- ✓ Need to improve the discussion on the prevention of custody relinquishment to access services.
- ✓ Show the work being done on pre-vocational coordination between mental health and vocation rehabilitation.
- ✓ Page 29 goal three, caution this identifies the population children that are wards of the State ... do not want to perpetuate this ... do not want to use relinquishment to State.
- ✓ Visions for Tomorrow is sponsored by NAMI
- ✓ Wrap Around services are available to anyone in Managed Care. There is a misunderstanding about Wrap Around
- ✓ Family Center Practice – in Protection and Safety ... Fund Integrated Care Coordination and Wrap Around – need another term? *Real choice committee uses a Person centered planning approach. Principles in family Centered and Warp Around. Take a look into integrating Real Choice Grant Guiding Principles and the Core Competencies to help address the Person Centered Planning.
- ✓ integrating systems ... Add input and information from alternative schools
- ✓ Regional Youth Specialists – have them put this information in their reports
- ✓ Vocational Rehabilitation connects with schools on transition kids
- ✓ Page 10 - Update ICCU Information under Criterion 1 – page 10 ... Refer to school system for Child Abuse Prevention Treatment Act.

Federal Requirements / Planning Council documentation ... letter signed by the Chair

Nebraska State Advisory Committee on Mental Health Services

August 27, 2004

Ms. LouEllen M. Rice
Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

Please regard this letter as the documentation demonstrating that the FY 2005 Nebraska Community Mental Health Services Block Grant Application was shared with the new State Advisory Committee on Mental Health Services. On August 19, 2004, at the first meeting of this Nebraska State Advisory Committee, a review of the draft FY 2005 Application was completed. The Adult and Child plans were reviewed separately after presentation by HHSS staff. The Committee members asked many questions, commented and made recommendations.

Under LB1083 Section 14 the State Advisory Committee on Mental Health Services was established. Section 14 (2) (a) states that the Committee shall serve as the State's mental health planning Council as required by Public Law 102-321. The state statute authorizing the former Nebraska Mental Health Planning and Evaluation Council was repealed under LB1083 (149).

During the review of the draft FY 2005 Application the Committee, concerns were expressed that there was inadequate time to review the draft Application. It was requested that more time be given in the future to review the draft. Concerns were also expressed about the continuity and sustainability of the Suicide Prevention Initiative as it appeared that it lacked state funds when federal funds were possibly available. Lastly, the Committee requested that an earlier review of the Community Mental Health Services Block Grant Application would include wider notice to the public for more extensive comments and inclusion.

Initial Committee questions pertained to the infrastructure and inclusion of the State Advisory Committee on Mental Health Services as created by LB 1083. It was concluded that a full description would be part of the annual orientation for Committee members. The Committee also asked that consumers be notified and included in the review of the draft Application in the future. As stated in the request of HHSS, it was asked that funding be obtained for the Suicide Prevention Initiative to replace volunteers. It was also asked that consumers or consumer specialists, who are currently involved as volunteers to be considered as employees, worthy of reimbursement for their services. In addition, it was noted that the description of the "Gap on Cultural Competence" was non-specific and asked that HHSS develop a broad plan be developed and implemented. It was noted that there are current state projects that are ongoing that include "wrap around", "person centered planning", and "Real Choice for Nebraskans" from which to draw upon.

Nebraska 2005 Community Mental Health Services Block Grant Application / August 27, 2004

The Committee was encouraged by the extensive planning and development of the Community Mental Health Services Block Grant Application FY2005 by HHSS. The sensitivity, open responsiveness, and willingness of HHSS to be more inclusive of consumers and cultural awareness was particularly encouraging for the Committee. Also, the Committee was pleased that HHSS recognized the importance of more timely preparation and public review of the draft Application in the future. It was noteworthy by the Committee that all of the Public Comment during the meeting came from mental health consumer advocates. It serves as an awareness that consumer activity in Nebraska is becoming stronger as it has become in other states and nationally, demonstrating that Nebraska is trying to catch up with the current trends nation wide.

The Committee took careful time and consideration before approving the draft Application. The Committee agreed that it insists upon its request of HHSS to seriously consider the Committee's request and questions asked to be adequately addressed. Staff of HHSS made the assurances sufficient to the Committee. Discussion ensued, with agreement on and approval of the FY2005 Application by the State Advisory Committee on Mental Health Services was accepted unanimously.

Sincerely yours,

Richard Ellis, Interim Chair
Nebraska State Advisory Committee on Mental Health Services

Nebraska 2005 Community Mental Health Services Block Grant Application / August 27, 2004

Federal Requirements

PART B. Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance / Public Comments on the State Plan

Here is the system used to provide opportunity for the public to comment on the State Plan. This method is based on the approaches used with the former Nebraska Mental Health Planning and Evaluation Council. A similar approach is being developed for the "State Advisory Committee on Mental Health Services".

1. Meetings for the next calendar year are usually scheduled at the fall meeting.
2. Notice of the next officially scheduled meeting is sent to the members of the "State Advisory Committee on Mental Health Services" 3-4 weeks in advance.
3. A notice of public meeting is published in the Lincoln Journal Star 10 days in advance of the next scheduled meeting.
4. On 08/11/2004, the notice of the first official meeting of the Mental Health Advisory Committee was posted on the Nebraska State Agency Calendar. It is designed as a bulletin board for announcing activities/events that would be of interest to the general public.

See <<http://www.nol.org/calendar/activity.cgi>>. The listing read as follows:

Date	Time	End	Activity of	Agency	Location	Last Updated
Thursday, 8/19/2004	1:00 pm	5:00 pm	Mental Health Advisory Committee	Health & Human Services (HHS)	Country Inn and Suites, 5353 North 27th Street, Lincoln NE	15:29, 08/11/2004

5. The agenda for the next scheduled meeting is posted on the web site. The agenda includes a time period when public comments may be received. At the August 19, 2004 meeting of the "State Advisory Committee on Mental Health Services", members of the public are welcomed to comment on the proposed application. Copies of the draft plan are made available to public at the meeting. A similar approach is used with the Implementation Report due on December 1 each year.

Federal Requirements

PART C. STATE PLAN

SECTION I. Description of State Service System

- An overview of the State's mental health system
- A description of how the State mental health agency provides leadership

There are some major changes underway in Nebraska at this time. The "**Nebraska Behavioral Health Services Act**" (**LB 1083**) was approved by the Governor on April 14, 2004. LB1083 represents a major reform of the Nebraska Behavioral Health System. LB1083 Section 4.(2) defines a "Behavioral Health disorder" as "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder". LB1083 establishes a revised framework for the provision of behavioral health services in Nebraska. For more information on LB1083 and the Governor's Behavioral Health Reform Initiative, visit the Nebraska Health and Human Services web site and click on "Adult Behavioral Health Reform"

<<http://www.hhs.state.ne.us/beh/reform/>>. From that web site you may learn more about the

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History of LB1083, the Implementation Plan, Frequently Asked Questions (FAQs), Employee Information, Mental Health Services, Service Regions and more. Coming soon to this web site will be more on the Process and Consumer Information.

HHSS

The Nebraska Partnership Act (1996), effective on January 1, 1997, created the Nebraska Health and Human Services System (HHSS). HHSS is made up of three functional agencies, the Department of Health and Human Services (HHS); the Department of Health and Human Services Finance and Support (HHS/F&S); and the Department of Health and Human Services Regulations and Licensure (HHS/R&L). The State Medicaid authority is located in HHS/F&S. For more information about HHSS visit <<http://www.hhs.state.ne.us/>>.

Policy Cabinet: The Nebraska Health and Human Services System (HHSS) Policy Cabinet governs this State of Nebraska agency. The Policy Cabinet consists of the three agency directors, a Policy Secretary, and the Chief Medical Officer. Governor Mike Johanns (R) took office in January, 1999. He appoints the HHSS Policy Cabinet. The HHSS Policy Cabinet members are:

- Chris Peterson – the NE Health and Human Services System Policy Secretary.
- Nancy Montanez, Director, NE Department of Health and Human Services (HHS).
- Dick Nelson, Director, NE Department of Health & Human Services Regulation & Licensure
- Steve Curtiss, Director, NE Department of Health and Human Services Finance & Support
- Dr. Richard Raymond – the Nebraska's Chief Medical Officer.

HHS: The Department of Health and Human Services (HHS) has local offices across the state that are organized into five service areas. In addition, the Department oversees 10 facilities, including four Veterans' Homes, three regional centers, two youth rehabilitation and treatment centers, and the Beatrice State Development Center. Organizational Structure for the Department of Health and Human Services (HHS) is

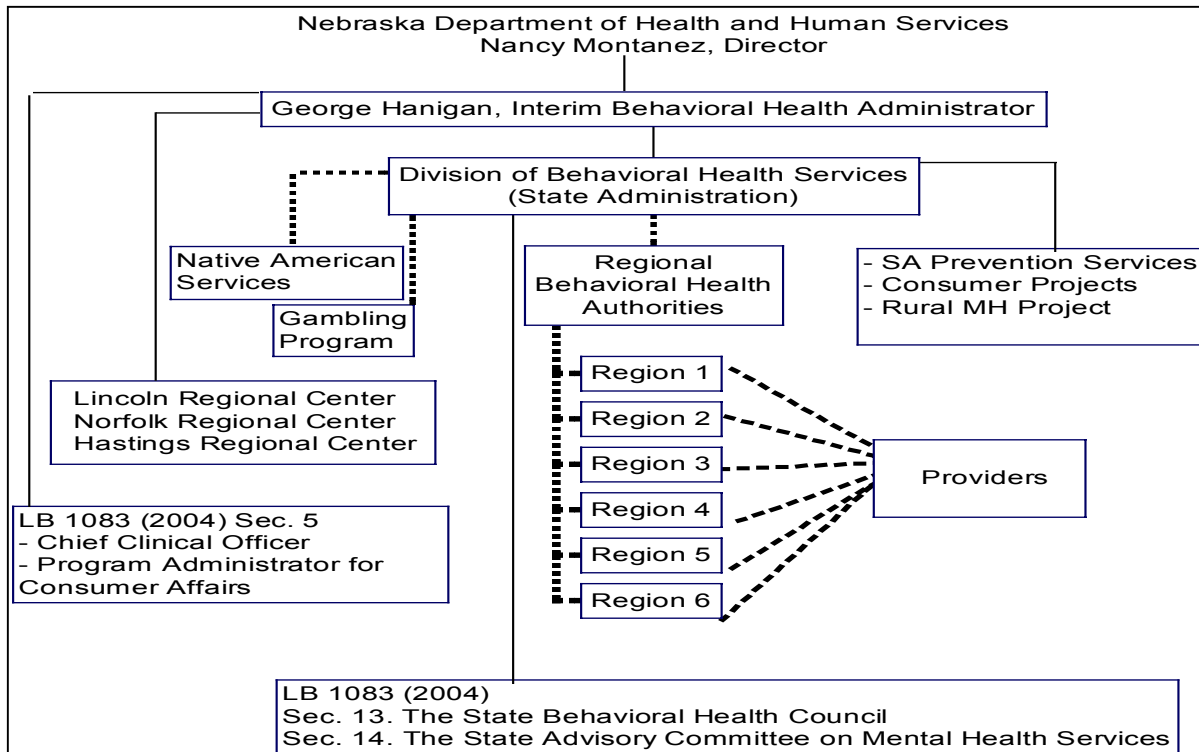
- Nancy Montanez, Director
- Dennis Loose, Chief Deputy Director for Health and Human Services
- George Hanigan, Interim BH Administrator - Community-based Mental Health/Substance Abuse, Compulsive Gambling, Regional Centers, Aging and Disability Services.
- Mary Boschult - Office of Administration
- Roméo Guerra - Deputy Director for Health Services

LB1083 Section 5 (2) says the Administrator of the Division shall be appointed by the Governor and confirmed by a majority of the members of the Legislature. On July 20, 2004, Nancy Montanez designated George Hanigan the Interim Behavioral Health Administrator. The chart below shows the Interim Behavioral Health Administrator's role with the Community-based Mental Health/Substance Abuse, Compulsive Gambling, and Regional Centers. Excluded from the table is the Administrator's role in Aging and Disability Services.

L. Blaine Shaffer, MD is the Medical Director for HHS. Dr. Shaffer is under contract from the University of Nebraska Medical Center, Department of Psychiatry (Professor, Adult Psychiatry, Vice Chairman for Clinical Affairs). Most of Dr. Shaffer's time is with the Behavioral Health

Services Division, Regional Centers, Beatrice State Development Center and the Veteran Homes. His first day was July 1, 2003.

The initial interviews for the position of Administrator of the Division of Behavioral Health Services began on July 28, 2004. Governor Johanns will make the final appointment. HHSS intends that the administrator be appointed no later than September 30, 2004. After this appointment is completed, the chief clinical officer and program administrator for consumer affairs as provided in LB 1083 will be selected.



HHS is a direct service provider of mental health services through three State Psychiatric Hospitals (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center). One of the intents of LB1083 is to reduce the necessity and demand for regional center services.

Community Mental Health

Under the Nebraska Behavioral Health Services Act (LB1083):

- Section 5. (1) Establishes the Division of Behavioral Health Services within the Department.
- Section 6. (1) The Division of Behavioral Health Services shall act as the chief Behavioral Health authority for the State of Nebraska.

On July 1, 2004, the functions of the Office of Mental Health, Substance Abuse and Addiction Services were added to the new Division of Behavioral Health Services. As part of the Behavioral Health Reform, HHSS is reviewing the internal organization needed to be in place in order to implement LB1083. At this time, the primary role involves State administration and management of non-Medicaid public behavioral health services through Regional and direct service contracts. In that capacity, the Division provides a state leadership role as the Mental

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Health Authority and State Substance Abuse Authority. This leadership role involves a number of different areas including but not limited to:

- Funding, contracting, & monitoring community mental health & substance abuse services
- Behavioral Health System Management and Information Management via Administrative Services Only contract with Magellan Behavioral Health.
- State Behavioral Health Standards (Regulations, Contracts, other related policy)
- Training/Technical Assistance
- Planning / Define Services / Establish Rates
- Professional Partner Services (Mental Health Children's Services only)
- Consumer Empowerment Projects including LB 1083 Section 5 (3) to establish an Office of Consumer Affairs.
- Gambling Assistance Program
- Substance Abuse Prevention Programs
- Mental Health and Substance Abuse funding for Native American Tribes
- Mental Health Commitment Board Training [LB1083 Section 36 (1)]
- Statewide MH Disaster Preparedness & Response / Critical Incident Stress Management
- Pre-admission Screening / Annual Resident Reviews
- State Behavioral Health Council (LB1083 Sec. 13)
- State Advisory Committee on Mental Health Services (LB1083 Sec. 14)
- State Advisory Committee on Substance Abuse Services (LB1083 Sec. 15)
- State Advisory Committee on Problem Gambling and Addiction Services (LB1083 Sec. 16)
- Federal Grants Management including:
 - PATH Homeless Services
 - SA Needs Treatment Assessment
 - MH Data Infrastructure Grant

ASO for MH/SA Services

Starting in 1995, there has been a Medicaid managed care contract for mental health and a separate contract for behavioral health. Two organizations had been providing managed care services to mental health / substance abuse programs. Now Magellan Behavioral Health handles the Managed Care Admistration Service Organization (ASO) Mental Health and Substance Abuse (MH/SA) services contract. The Magellan Behavioral Health (Magellan) contract covers both Medicaid (Managed Care Program and Medical Assistance Program) and the Nebraska Behavioral Health System (NBHS). The contract covers a three year time period, and a possible three year extension. The Medicaid portion of this started July 1, 2002. This contract was converted to the ASO format. The Nebraska Behavioral Health System (NBHS) portion started January 1, 2003.

ASO Contract & Data Collection - The data base used for community behavioral health programs was moved to Magellan Behavioral Health during the first contract cycle. Community based data collection by Magellan was implemented on July 1, 1997 and community-based utilization management was initiated in December of 1997 for those services requiring authorization.

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The current contract portion covering Nebraska Behavioral Health System (NBHS) started January 2003. The Magellan Behavioral Health data system revisions are scheduled for implementation in October 2003. The revised 117 data fields for the NBHS cover

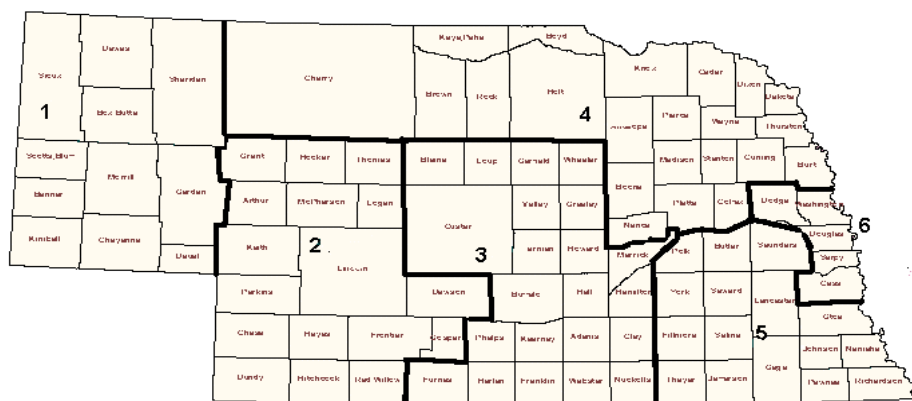
- Community mental health, community substance abuse, and the gamblers assistance program
Sections such as demographics, admission status data, children/adol (0-18), history of substance abuse, service / authorization, financial eligibility, discharge status.

PART C. STATE PLAN / Section I. Description of State Service System

A brief description of regional/sub- State programs

The mental health regions were initially established in 1974. LB1083 (sections 7-9) revises the regional administration of the Nebraska Behavioral Health System. LB1083 retains the current six geographic behavioral health “regions.” Section 7 assigns all 93 counties to one of six Behavioral Health Regions. LB1083 renames the regional administrative entity as a **Regional Behavioral Health Authority (RBHA)**, to mirror designation of the Division as the state’s chief behavioral health authority. Regional Governing Boards are retained, consisting of one county board member from each county in the region. The administrator of the RBHA is appointed by the regional governing board. The RBHA is responsible for the development and coordination of publicly funded behavioral health services in the region pursuant to rules and regulations of the Department.

Region	Regional Office	Counties	Population (2000)	% of population
1 (Panhandle)	Scottsbluff	11	90,410	5.3%
2 (West Central)	North Platte	17	102,311	6.0%
3 (South Central)	Kearney	22	223,143	13.0%
4 (Northeast & North Central)	Norfolk	22	216,338	12.6%
5 (Southeast)	Lincoln	16	413,557	24.2%
6 (Eastern)	Omaha	5	665,454	38.9%
Totals		93	1,711,213	100.0%



A Map of the Six Behavioral Health Regions

Funding required of counties for the operation of the RBHA and for the provision of behavioral health services within the region remains the same. Any additional General Funds made

available for the provision of community-based services due to any reduction in regional center services may not be included in the county matching fund calculation.

The bill prohibits the regions from directly providing services except under very limited circumstances. LB1083 Section 9 (2) does provide exceptions. One exception is a regional behavioral health authority may continue to directly provide services it operated on July 1, 2004.

Each regional behavioral health authority must continue to utilize a regional advisory committee consisting of consumers, providers, and other interested parties, and may establish and utilize other task forces or committees as necessary and appropriate to carry out its duties under the act.

Federal Requirements

Section I.

- Significant achievements in its previous fiscal year
- New developments and issues that affect mental health service delivery in the State
- Legislative initiatives and changes

SECTION II. Identification & Analysis of the Service System's Strengths, Needs and Priorities

- A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

This section will be discussing the Governor's Behavioral Health Reform Initiative and the passage the Nebraska Behavioral Health Services Act (LB 1083). The Governor's Behavioral Health Reform Initiative covers a number of areas including significant achievements during the last year that reflect progress towards the development of a comprehensive community-based mental health system of care, new developments and issues that affect mental health service delivery in the State, as well as legislative initiatives and changes.

Governor's Behavioral Health Reform Initiative

For the last several years, Governor Mike Johanns has publicly stated that behavioral health reform was his priority.

- LB 724 (2003): Established a "roadmap" for reform of the public behavioral health system and outlined focus areas for reform. Both Senator Jim Jensen and Governor Johanns were involved in "Nebraska Behavioral Health Reform Act" (Legislative Bill 724-2003). This bill was approved by the Governor on May 13, 2003. The purpose of LB724 was to indicate legislative intent for reform of the behavioral health system and for a substantive recodification of statutes relating to the funding and delivery of behavioral health services in the State of Nebraska.
- LB 710 (2003): Proposed recodification of the Nebraska Mental Health Commitment Act.
- In the Lincoln Journal Star (June 9, 2003), Governor Mike Johanns said, if he was forced to pick just one area he could influence during his remaining days as Governor, it would be **mental health**.
- In that same article Omaha Senator Jim Jensen, Chair of the Health and Human Services Committee of the Nebraska Legislature, said he is looking for ways to provide more housing and treatment services in local communities and examine the need for three regional centers.

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- LB 1083 (2004): Implemented the reform intent in the focus areas of state leadership, regional administration, statewide advocacy, funding, and legislative oversight. It requires planning for the statewide development of community-based behavioral health services and reduction in the necessity and demand for regional center services.
- In 2005: Further legislative review based upon the progress of planning and initial implementation of LB 1083.

In his "State of the State Address" on January 15, 2004, Governor Johanns said one of his five goals for the legislative session was mental health reform. Two of the seven pages of the Governor's address were devoted to the mental health reform. The Governor said, "First, I implore you to reform our mental health system. Senator Jensen and I have worked on mental health reform virtually every day since the last day of the last session. He has courageously put forth LB 1083 to achieve this reform." The Governor went on to say, "We have a compelling moral responsibility to see that these individuals are cared for in the least restrictive environment". The Governor also said, "The legislation before you is the right thing to do. It commits us to a course of recovery for these citizens in their communities, near their support systems". For the complete text of the Governor's address, see <http://gov.nol.org/johanns03/speeches/sos2004/index.html>.

On April 14, 2004, Governor Mike Johanns signed into law Legislative Bill 1083, the Nebraska Behavioral Health Systems Act (LB1083). The final vote in the Nebraska Legislature was 44 in favor, 2 against, 3 not voting. Introduced by Senator Jim Jensen, this historic legislation reforms Nebraska's behavioral health services by moving from an over-reliance on state-owned Regional Centers to creation or expansion of acute inpatient, secure residential and support services in the community. LB 1083 provides services closer to home and in the least restrictive, appropriate setting while accessing federal Medicaid dollars. LB1083 addresses issues relating to behavioral health services, mental health commitments, affordable housing, and alcohol and drug abuse counselors. LB 1083 represents implementing legislation required by LB 724 (2003). LB1083 will eventually close the regional centers in Hastings and Norfolk to create more community-based programs for treating behavioral health disorders. More information on LB 1083 can be accessed at the HHSS website at <http://www.hhs.state.ne.us/beh/reform/>.

Mechanism to Close a Regional Center

As noted above, LB1083 creates the Division of Behavioral Health Services, within the Nebraska Department of Health and Human Services. LB1083 Section 10 provides key directions for the changing of the Behavioral Health System in Nebraska

- Section 10 (1) instructs the Division to encourage and facilitate the Statewide development and provision of an appropriate array of Community-Based Behavioral Health Services and continuum of care.
- Section 10 (2) says the Division may reduce or discontinue Regional Center Behavioral Health services only if appropriate community-based services or other Regional Center Behavioral Health services are available for every person receiving the Regional Center services that would be reduced or discontinued.
- Section 10 (6) says the division is to notify the Legislature and Governor when occupancy of the licensed psychiatric hospital beds of any Regional Center reaches 20% or less of its

licensed psychiatric hospital bed capacity on March 15, 2004. The Legislature's Executive Board may grant the division permission to close the center and transfer any remaining patients to appropriate community-based services.

- Section (7) states that the provisions of Section 10 are self-executing and require no further authorization or other enabling legislation.

Core Principles of Behavioral Health Reform

- Consumers will have services that better meet their needs and are closer to their families and communities
- Community services must be in place before patients are transitioned
- Acute and Secure hospital levels of care will continue to be required
- Current funding will be leveraged with Medicaid match dollars and re-invested in the appropriate community services
- Reform will happen in incremental steps

Key events and timelines in LB 1083 include:

- (1) On June 16, 2004, Senator Jim Jensen announced appointments to the Behavioral Health Oversight Commission of the Legislature. The commission was mandated in LB 1083 Section 18. The members of the Behavioral Health Oversight Commission (commission) were appointed by Senator Jensen and confirmed by members of the Health and Human Services Committee (committee). The first meeting of the commission was held on Friday, July 9, 2004. Commission meetings are open to the public. Future commission meetings will be on the second Friday of each month through December 2004. Future meeting dates are as follows: August 13, September 10, October 8, November 12, and December 10. Meeting locations will be announced. The committee has directed the commission to take all necessary and appropriate steps as permitted by law to ensure that input is received from consumers of behavioral health services and from all areas of the state, including those areas that are underserved and not currently represented on the commission.
- (2) On July 1, 2004 the Nebraska Health and Human Services System (HHSS) submitted a Behavioral Health Implementation Plan (BHIP) as required by LB1083 sections 19-20. A complete PDF version of the 208-page document and other information regarding implementation of LB 1083 can be accessed at the HHSS website at <http://www.lhs.state.ne.us/beh/reform/>.
- (3) The Commission is to review and make recommendations relating to the BHIP on or before October 1, 2004.
- (4) HHSS is to respond to the Commission recommendations on or before December 1, 2004; and
- (5) Follow-up legislation may be introduced in the Nebraska Legislature in January 2005.

Section I – Envisioned By State In The Future

As noted above, Governor Mike Johanns made his State of the State address on January 15, 2004. He included statements on his vision for the future such as,

"We have worked directly with citizens who have mental illnesses and they have moved and impressed me. They are not weak people; they are not troubled people; they are people who have an illness. They merely seek understanding as they work daily toward their recovery. With

treatment, many are undaunted by the burden of their illness only to be held back by a stigma that has no rightful place in our society today, yet sadly continues. It is time to open the doors and shine light on the dramatic advances in treatment."

The "Nebraska Behavioral Health Services Act" (LB 1083) was approved by the Governor on April 14, 2004. LB1083 provides a vision of the mental health system in the future. LB1083 will eventually close the regional centers in Hastings and Norfolk to create more community-based programs for treating behavioral health disorders. It creates the Division of Behavioral Health Services, which the state Department of Health and Human Services will oversee. The division is to notify the Legislature and Governor when a regional center reaches 20 percent or less of its capacity. The Legislature's Executive Board would then grant the division permission to close the center and transfer patients to appropriate community-based services.

As noted above, on July 1, 2004, the Nebraska Health and Human Services System (HHSS) submitted a Behavioral Health Implementation Plan (BHIP) as required by LB1083 sections 19-20. According to an editorial from the July 6, 2004 Omaha World Herald, an outline of the future is starting to emerge. The editorial noted the plan may prove to be a good guide toward the flexible, progressive future the state so sorely needs for adults with serious mental illness. The editorial notes the logistics of the changeover could be tricky, involving the downsizing and closing of regional facilities that should be balanced by the upgrading and opening of community services. The editorial said what is needed now is a spirit of cooperation across the state to make these worthy goals become reality.

Observations from the July 6, 2004 Omaha World Herald editorial included:

- > Some of the goals of the reform, ordered by the Legislature last session, are to decentralize the system, rationalize the distribution and use of mental-health services around the state and provide services in a more efficient, convenient way.
- > The plan offers both generalities and specifics. It proposes spending \$1.1 million to expand crisis response services and other necessary improvements in the Panhandle region, \$6 million in eastern Nebraska and varying amounts in the state's other four mental-health regions.
- > Perhaps its most noticeable effect: The closing of the Hastings and Norfolk Regional Centers in favor of community-based care and treatment, including such services as group homes, crisis intervention and emergency treatment.
- > It also sets out six possible schedules for closing the regional centers, depending on alternative services and financial considerations. The quickest closure could be this October for Hastings and December 2005 for Norfolk. The latest would close Hastings in February 2005 and Norfolk in March 2006.

Section I – Areas needing particular attention

July 6, 2004 Omaha World Herald editorial also noted some questions remain unaddressed:

- > The ability of the mental- health system to keep potentially dangerous patients away from the public is always a concern when community-based services are offered.
- > The impact of closing the regional facilities on the communities of Hastings and Norfolk.

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- > Due to the uncertainties of the way the new system will be managed, the interactions of a state government that often has been cumbersome and slow-moving and a system of mental-health regions that may need quick decision-making and, perhaps, shifts in funding.

For the Child and Adult Plans

Federal Requirements / SECTION II

- strengths/weaknesses of the service system
- analysis of unmet service needs/gaps ... note source of information ...

Strengths Of The Service System

Most of this document outlines the strengths of the State of Nebraska Behavioral Health System.

Some of the key points include:

- Governor's Behavioral Health Reform Initiative
- Legislative support for the initiative. The final vote was 44-2 (3 not voting) on April 14, 2004
- There is an established system of community mental health services dating back to 1974.

Weaknesses Of The Service System

Analysis Of Unmet Service Needs/Gaps ... Note Source Of Information ...

UNMET NEEDS / GAPS

The analysis of unmet service needs and gaps presented in this section represents an overview of the weaknesses of the service system in Nebraska.

GAP #1: THE DISCREPANCY BETWEEN PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.

The prevalence of mental illness is the estimated total number of cases of a disease in a given population at a specific time. The penetration rate is the number of individuals with these diseases being served by the public and private sectors in Nebraska.

Federal Uniform Reporting System / NE Implementation Report 2003.

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

- Data limited to community mental health as reported to Magellan Behavioral Health for the Office of Mental Health, Substance Abuse and Addiction Services.

	Female	Male	Not Available	Total
0-3 Years	92	133	20	245
4-12 years	396	656	0	1,052
13-17 years	495	641	0	1,136
18-20 years	433	491	0	924
21-64 years	8,259	7,635	5	15,899
65-74 years	214	131	1	346
75+ years	142	96	0	238
Not Available	12	13	0	25
Total	10,043	9,796	26	19,865

CHILDREN

As with the adult definitions, the prevalence rate of serious emotional disturbance is defined as the estimated total number of cases of children diagnosed with SED in the state of Nebraska at a specific time. Data on the prevalence rate of SED children indicates:

Summary – Penetration Rate / Child SED

22,842	SED estimated by CMHS
2,161	Child SED / URS Table 14A NE FY2003 Implementation Report
9.46%	Penetration rate

NOTE 1: Uniform Reporting System (URS) Table 14A for FY2003 requested counts for Persons Served with SED using the definitions provided by the CMHS.

NOTE 2: These data do not include the services provided by the HHS Protection and Safety nor Medicaid.

URS Table 1: Estimated Number of Children and Adolescents, Age 9 to 17, with Serious Emotional Disturbance, by State, 2002 / Federal Center for Mental Health Services

	Number of Youth 9 to 17	Age 5 - 17 Percent in Poverty	State Tier for % in Poverty	Level of Functioning Score=50		Level of Functioning Score=60	
				Lower Limit	Upper Limit	Lower Limit	Upper Limit
Nebraska	228,421	10.9%	Low	11,421	15,989	20,558	25,126

22,842 SED estimated

URS Table 14A (Nebraska FY2003 Implementation Report).

- Profile of Persons with SMI/SED served - This table requests counts for persons with SED using the definitions provided by the CMHS.
- Data limited to community mental health as reported to Magellan Behavioral Health for the Office of Mental Health, Substance Abuse and Addiction Services.

	Total			
	Female	Male	Not Available	Total
0-3 Years	88	134	8	230
4-12 years	339	540	0	879
13-17 years	490	562	0	1,052
Total SED	917	1236	8	2,161

Services in the public system are primarily available to specific target groups, including children who are state wards, children who are involved in the legal system, and children with families with no insurance or financial resources. This gap in service exists primarily because the need is great and funding resources are limited. Therefore, funds have been targeted to provide services for very specific groups of children and their families. Unfortunately, one way to access services for children is for parents to relinquish custody of their children, deeming them state wards, and making them eligible for services. Another circumstance is allowing children to fail to the point where they violate the law. Children then fall into one of the designated service categories and are able to access services. This is not an acceptable state of affairs. Appropriate service models are effective and available, but without adequate funding to serve children in need, we will

continue to pay the price later by forcing children into higher levels of care and/or into the legal system.

NOTE 2: This provides more information regarding NOTE 2. Unfortunately, Nebraska does not have the capacity to determine the penetration rate of all systems for children with serious emotional disturbance. Because a number of systems (Nebraska Behavioral Health System, Medicaid, Office of Protection and Safety, including child welfare and Juvenile Justice, Education and Corrections) may provide some sort of mental health service for children with SED and their families, it is difficult to gather data as to an unduplicated count of children receiving services. An information system is not available which is able to synthesize data on children receiving services across multiple systems; data is not available on the number of children not receiving services. Given the anecdotal data which indicates a large number of children needing services are not receiving them, one might theorize that some populations of children may be “over-served” while others remain unserved because they are outside the eligibility boundaries of child serving systems with adequate funding for mental health care.

The Nebraska Behavioral Health System (NBHS) is the publicly funded, non-Medicaid program. Calculation of the penetration rate is limited to those served within NBHS and reported on the Magellan Behavioral Health Information System. The penetration rate should be the number of children with this diagnosis receiving services through the Nebraska Behavioral Health System (NBHS), Office of Protection and Safety System, including Child Welfare and Juvenile Justice Systems, and others receiving services funded by Medicaid or private insurance. Most significantly, the lack of complete penetration data makes it difficult to plan for services for children when the gaps are not readily apparent.

ADULTS

The US Department of Health and Human Services, Center for Mental Health Services (CMHS) estimates the Number of Persons (Civilian Population) with Serious Mental Illness (SMI), age 18 and older is 69,648. The Nebraska Behavioral Health System (NBHS) is the publicly funded, non-Medicaid program. In FY2003, NBHS served 8,308 persons who were identified as having a Serious Mental Illness (SMI). Using these figures, 11.9% (69,648) of the people who SMI were served by NBHS (penetration rate for NBHS).

Summary – Penetration Rate / Adult SMI

69,648	SMI estimated by CMHS
8,308	Adult SMI Served / URS Table 14A NE FY2003 Implementation Report
11.93%	Penetration rate

URS Table 1: Number of persons with serious mental illness, age 18 and older, by State, 2002

	Resident Population Population 2002	Resident Population with SMI (5.4%)	Lower Limit of estimate (3.7%)	Upper Limit Of estimate (7.1%)
Nebraska	1,289,787	69,648	47,722	91,575

source: Deborah Baldwin; 7/20/2004 Federal Center for Mental Health Services (CMHS)

URS Table 14A (Nebraska FY2003 Implementation Report).

- Profile of Persons with SMI served - This table requests counts for persons with SMI using the definitions provided by the CMHS.
- Data limited to community mental health as reported to Magellan Behavioral Health for the Office of Mental Health, Substance Abuse and Addiction Services.

	Total			
	Female	Male	Not Available	Total
18-20 years	162	156	0	318
21-64 years	4,041	3688	5	7,734
65-74 years	112	56	1	169
75+ years	52	35	0	87
Total SMI	4,367	3,935	6	8,308

In looking at these figures, it is important to remember that the persons served data from FY2003 is limited to the Nebraska Behavioral Health System (NBHS). NBHS is the publicly funded, non-Medicaid program. It is also important to remember the role of Medicaid, the Criminal Justice System, the private sector (health insurance and self pay) and other related areas in addressing the needs of these populations. Thus the gap here involves two areas:

1. Nebraska's capacity to determine the Prevalence and Penetration rate for individuals with mental illness.
2. The gap between the actual number of persons in need (prevalence) and the NBHS capacity to meet these needs (penetration rate).

SOURCE:

- Reviewed with the State Advisory Committee on Mental Health Services on 8//19/2004.
- URS Table 14A (Nebraska FY2003 Implementation Report).
- URS Table 1: Number of persons with serious mental illness, age 18 and older, by State, 2002
Deborah Baldwin <DBaldwin@samhsa.gov> 7/20/2004
U.S. Department of Health & Human Services
Substance Abuse & Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)

GAP #2:

DEVELOPMENTALLY APPROPRIATE SERVICES FOR YOUTH IN TRANSITION

Additional assessment of the ability of adult providers to work successfully with transitioning is needed to ensure developmental appropriateness of services. Adult providers are often unwilling to serve younger adults as their developmental needs are different than older adults, and/or should be met in a different manner than older adults' needs. Nebraska Behavioral Health System data indicates that three Mental Health age waivers were requested to authorize services for youth ages 17 & 18 who were unable to be served in youth systems. The Office of Mental Health, Substance Abuse and Addiction Services provides funding for youth in transition to adult mental health services through an age waiver program (for children 17 and 18,) allowing youth to access appropriate adult services that are traditionally unavailable to transition-aged youth. The burden is on the provider to communicate and provide a developmentally appropriate adaptation of the service to the transition-aged youth. Additional assessment of the ability of

adult providers to work successfully with transitioning is needed to ensure developmental appropriateness of services.

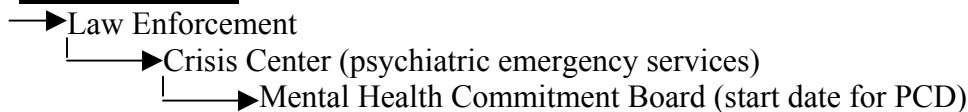
Source: Reviewed with the State Advisory Committee on Mental Health Services on 8//19/2004. July 21, 2003 meeting of the Planning Team of the Office of Mental Health, Substance Abuse and Addiction Services; 2003 LB 433 Reports; NBHS Annual Age Waiver Summary

GAP #3: LACK OF ADEQUATE “STEP DOWN” SERVICES

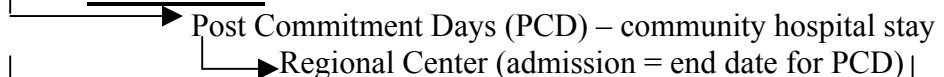
This is looking at the "consumer flow" of adults through the Nebraska Behavioral Health System (NBHS). This flow starts with the individual going to psychiatric emergency services, into inpatient for treatment, followed by lower levels of care suitable for the consumer's needs.

MENTAL HEALTH AND SUBSTANCE ABUSE -- CONSUMER FLOW

EMERGENCY



INPATIENT



OUTPATIENT and other related less restrictive alternatives

RESIDENTIAL SERVICES – Group Residential Beds – facility based, non-hospital or nursing home, group living with on site staff.

NON-RESIDENTIAL MENTAL HEALTH SERVICES

Independent Living in Residential Units (apartments, single room occupancy) that are affordable, decent, safe, and appropriate for people who are extremely low income with SMI with community mental health support services.

There are a number of problems triggering this gap. Many involve the fragmented behavioral health system in Nebraska. There are a number of different funding streams such as Medicaid, NBHS, Protection & Safety, and private health insurance. Each funding stream has its own clinical and financial eligibility requirements. The funding levels do not provide enough incentives for individuals to select mental health as a career, leading to staffing shortages (see next gap).

These problems lead to a focus on public safety issues being a priority. Areas such as psychiatric emergency services are addressed. However, there are many problems here. Richard Young Center, a psychiatric inpatient facility in Omaha, closed by April 2003. The beds had been used to serve unstable or suicidal patients. The closing of Richard Young eliminated 34 percent of Omaha's inpatient mental health beds, exacerbating the current problems.

However, there is no good flow through the system, leading to "Post Commitment Days". "Post Commitment Days" (PCD) are defined as the number of days between the date of mental health board civil commitment to inpatient care at a Regional Center and the date of admission to the Regional Center. A statewide summary on "Post Commitment Days" shows in FY2002 there were 5,633 PCD. In FY2004, "Post Commitment Days" were reported as follows:

- HRC from July 2003 to May 2004 = 480 (HRC no longer taking acute clients)
- NRC from July 2003 to June 2004 = 3,953
- LRC from July 2003 to June 2004 = 567

The total in FY2004 is 5,000. That is 633 below the FY2002. It also means there are still problems in this area.

The front end of the cycle is triggered when there is not enough housing that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness. Housing problems for people with serious mental illness lead to increased demand for emergency psychiatric services, increased length of stay in inpatient psychiatric services, and homelessness.

The need for housing in community settings that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness would help to address this. With this housing, an adequate supply of the lower levels of care for mental health services needs to be included.

The Governor's Behavioral Health Reform initiatives are designed to help change this. The community based services expanded should eliminate the need for post commitment days. Also, LB1083 Section 101 amended the Nebraska Affordable Housing Trust Fund (NE Statute section 58-706) to add "(12) Rental assistance for adults with serious mental illness" as an activity that is eligible for assistance.

SOURCE:

- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004.
- Nebraska Health and Human Services System, August 2004.
- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. (Lincoln, NE) which is planning focused on people who are extremely low income with serious mental illness needing housing. There are two projects covered in the contract:
 - Project #1 statewide consumer housing need study (July 24, 2003) and
 - Project #2- planning in four communities Omaha, Lincoln, the Norfolk Area & Tri-City Area (Hastings, Grand Island, and Kearney) (in process).
- "Dispute with BryanLGH over mental health bill spotlights LPD headache" July 27, 2003, Lincoln Journal Star
- Omaha World-Herald; February 14, 2003 - Lincoln Journal Star; February 26, 2003
- HHS Office of Mental Health, Substance Abuse and Addiction Services, July 25, 2003.

- Transition Project Charter (as of May 22, 2002) which is designed to impact the transition of consumers between the Regional Centers to community-based services through the development of processes and services.
- Mental Health Housing Planner Request For Proposals released on May 1, 2002.
- "Nebraska Mental Health Housing Coalition Planning Meeting" held on January 29, 2002.

GAP #4: INFORMATION SYSTEM IS INADEQUATE

There is a need to work on improving the management information systems used by the Office of Mental Health, Substance Abuse and Addiction Services. At minimum, there is a need to check for accuracy and provide feedback on data quality. NBHS, Medicaid and the Regional Centers each have their own data systems. There is no mechanism linking all three systems together.

As a result, there are various problems. These include being unable to effectively track consumers through the system, multiple requirements for data entry of the same information by the provider due to each funding source's needs, and the inability to receive timely and accurate reports on utilization of services.

The long term goal is to develop a single management information system to cover Community-based Mental Health, Substance Abuse, and the Regional Centers (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center). This includes improving provider participation in the information system. Such efforts are expected to result in improving the quality of data in the NBHS Management Information System. This also includes the need to improve the capacity to measure service capacity. This improved ability would be useful in managing the system as well as tracking gaps in services. It would also help in establishing performance measures. Under the current operations, it is very difficult to measure outcomes in relationship to funds expended.

In general, the data will be used to answer questions such as "who are we serving?" "What services are they getting?" and "What results were produced?"

Under Section 6 of LB1083, the duties of the new Division of Behavioral Health Services are listed. The duties include "(e) development and management of data and information systems".

From a consumer viewpoint, families are continually put in a position where services from system to system are not coordinated and the recommendations from system to system are not always on the same page. The paperwork is overwhelming for families who fill out duplicate forms in multiple system. This makes it very hard to be successful for families to meet every requirement if there is not a team approach to support the family. Progress is being made through the use of coordinated teams to get people and system on the same page but there are many legal and system barriers to sharing information. Trish Blakely, Healthy Families (August 11, 2004).

SOURCE:

- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004.
- Nebraska Health and Human Services System, August 2004.

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- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- Nebraska Mental Health Data Infrastructure Grant Application (First Year Application / June 19, 2001; Second Year Grant Renewal Application / March 18, 2002; and Third Year Grant Renewal Application / March 21, 2003)
- Office of Mental Health, Substance Abuse and Addiction Services Planning Team meeting, July 21, 2003

GAP #5: SHORTAGE OF CREDENTIALLED & ADMINISTRATIVE STAFF

There is a critical shortage of qualified Nebraska Behavioral Health Staff for providing treatment, rehabilitation and support services as well as handling administrative functions. The shortage of credential staff includes psychiatrists, psychologists, licensed mental health practitioners (LMHP), nurses and Alcohol/Drug Abuse Counselors. With all the increasing expectations on what the Nebraska Behavioral Health System (NBHS) needs to address, there also needs to be adequate supply of administrative personnel at all levels of operations.

Lack Of Expertise Available To Work With Persons With Dual Disorders

Substance abuse and dependence may go undiagnosed and untreated in adults with serious mental illness and children with serious emotional disturbance. Assessing substance abuse disorders is a key issue here.

This is especially a problem for children with serious emotional disturbance. All of the Nebraska Behavioral Health Regions throughout the state of Nebraska have expressed the need for more qualified staff and professionals, more specialized training for all non mental health staff and professionals who work with children diagnosed with a dual disorder (mental health and substance dependence).. There is a need to expand services in order to serve more youth in rural and frontier areas. Treatment professionals and educators, as well as parents in Nebraska would benefit from more education and training to assess and refer children for dual disorder treatment, and earlier intervention and assessment services. Furthermore, the need for more cooperation and communication between the mental health and substance abuse treatment systems, as well as other child serving systems.

Source: 2003 LB433 Report; Source: Office of Mental Health, Substance Abuse and Addiction Services Planning Team meeting, July 21, 2003.

LB1083 sections 103 – 125 amended the Uniform Licensing Law and the Requirements for Certified Alcohol/Drug Abuse Counselors (CADAC). As a result, there are now the following levels of certification:

- Licensed Alcohol/Drug Abuse Counselor (LADAC)
- Licensed Provisional Alcohol/Drug Abuse Counselor (LPADAC)
- Licensed Provisional and Licensed Mental Health Professionals Special Provisions.

Individuals certified at the CADAC level have reciprocity with other states and countries that are members of The International Certification And Reciprocity Consortium/ Alcohol and Other Drug Abuse, Inc., (IC&RC)

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The following comments were made by Donald E. Fischer, MD, DABFM, C.A.S.A.M., psychiatrist and medical addictionist, in private practice, Scottsbluff, NE and former Member of the MHPEC Executive Committee (08/05/2003) His comments included:

- The average physician without any special training or clinical experience may be able to diagnosis alcohol (and other) dependencies but not be prepared to recommend the level of treatment needed, depending on patient age, chronicity, prior treatment outcome, support system, and related areas. Therefore, additional training is usually needed.
- The same goes for a licensed psychologist without specific training in addictive and compulsive disorders.
- C.A.D.A.C.s are not qualified to go beyond basic substance dependence assessment. By training and licensure they are not qualified to recognize comorbid disorders such as Bipolar disorders, ADDH, OCD and other anxiety disorders, Axis II disorders, etc. Medical conditions accompanying substance dependence are beyond their purview, as well as the role of psychoactive medications (both dependency-producing and those needed in treatment, i.e.: antidepressants).

PSYCHIATRIC SHORTAGE AREAS

In Nebraska, Psychiatric Professionals, Primary Practice Locations:

	Psychiatry		Child / Adol. Psychiatry		Nurse Practitioners		Physician Assistants		Totals	
	#	%	#	%	#	%	#	%	#	%
Region 1	5	4%	1	5%	1	5%	0	0%	7	4%
Region 2	4	3%	1	5%	0	0%	0	0%	5	3%
Region 3	16	13%	3	14%	3	15%	0	0%	22	13%
Region 4	7	6%	0	0%	0	0%	2	40%	9	5%
Region 5	23	18%	3	14%	4	20%	1	20%	31	18%
Region 6	72	57%	13	62%	12	60%	2	40%	99	57%
Totals	127	100%	21	100%	20	100%	5	100%	173	100%

The supply of Nebraska Psychiatric Professionals is, based on their primary practice locations, as of January 30, 2002, according to the University of Nebraska Medical Center's Health Professions Tracking Center:

- Region 6, including the Omaha Metro Area
- Region 5, including the Lincoln Metro Area
- Region 4, the city of Norfolk
- Region 3, including the cities of Hastings, Grand Island, and Kearney
- Region 2, the city of North Platte
- Region 1, the city of Scottsbluff

Mental Health Professional Shortage Areas (MHPSAs) (page 39; 2003 Databook)

In 2003, the U.S. Department of Health and Human Services designated over 90 percent of Nebraska's counties (88 of 93) as MHPSAs. Based on 2000 census data, the population within these shortage areas (N = 1,045,809) exceeds 61 percent of the state's total population. One facility, the Hastings Regional Center, has also been designated as an MHPSA.

Health Professional Shortage Areas (page 40; 2003 Databook)

- Federally Designated Psychiatric Shortage Areas – 88 of 93 Nebraska Counties. The Omaha Metro Area / Region 6 are excluded. All other Nebraska counties are designated as "Psychiatric" shortage areas
- State Designated Psychiatric Shortage Areas – 87 of 93 Nebraska Counties with State Designated Shortage Areas - "Psychiatric" shortage areas. The six not designated were Buffalo, Dakota, Douglas, Lancaster, Sarpy, Scotts Bluff counties.

Mental Health Care Professionals (page 41; 2003 Databook)

Psychiatrists	140
Psychologists	330
Master Social Workers.....	610
Certified Professional Counselors	760
Licensed Mental Health Practitioners	1,795
Certified Marriage and Family Therapists	76

Nurse Shortage Counties

In nursing, 37 of 93 Nebraska's counties are considered to have a shortage, as of 11/04/02. The list of "Nursing Shortage County" is from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing <<http://bhpr.hrsa.gov/nursing/shortage.htm#ne>>.

Mental health is chronically under funded. To address the staffing issues, models of care must be adopted that allow the system to use the available expertise to the greatest extent possible. For example, general practice physicians, advanced practice nurses, and physician's assistants may be able to fill the roles of psychiatrists. In non-medical areas Licensed Mental Health Practitioners and Psychologists have filled traditional therapy roles. The use of physician extenders, non-physician program directors with psychiatric consultation, shared consumer management duties with other professions, and consultation over the internet are but a few of the ways that psychiatric expertise can be used.

Blaine Shaffer, MD (HHS Department of Health and Human Services Medical Director; the University of Nebraska Medical Center, Department of Psychiatry; and former member of the Mental Health Planning and Evaluation Council) commented on the shortage of psychiatrists in Nebraska.

"The point is that we need psychiatrists, not others acting as psychiatrists. One issue involved in medical students not choosing psychiatry is their perception that you don't have to be a trained psychiatrist to do psychiatry. Physician extenders are very helpful but should not replace psychiatrists.

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"Telepsychiatry could be a way for psychiatrists and other providers to collaborate and provide quality care for people in shortage areas. This modality is also currently underfunded."

For more information on the federal Health Professional Shortage Area status contact Thomas Rauner in the HHS Office of Rural Health and Primary Care (402-471-0148).

SOURCE:

- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004.
- Nebraska Health and Human Services System, August 2004.
- The Nebraska Health Information Project: 2003 Databook. (2003). Nebraska Center for Rural Health Research, University of Nebraska Medical Center.
- 2003 LB433 Report
- Thomas Rauner in the HHS Office of Rural Health and Primary Care, August 4, 2004.
- Blaine Shaffer, MD, HHS Medical Director; August 6, 2004
- "Rural Mental Health Aid Sparse" Lincoln Journal Star; Tuesday July 1, 2003
- Nebraska HHS Office of Rural Health & Primary Care (July 2004.) This office has the responsibility to review (and submit if appropriate) federal shortage area applications to the Shortage Designation Branch. This includes the Psychiatric Health Professional Shortage Area.
- University of Nebraska Medical Center's Health Professions Tracking Center; Nebraska Psychiatric Professionals; October 8, 2003.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Div. of Nursing
<<http://bhpr.hrsa.gov/nursing/shortage.htm#ne>>
- Nebraska Mental Health Planning and Evaluation Council meetings on August 16, 2001, February 4, 2002, and August 8, 2003.

GAP #6: MEDICATION ACCESS

This gap involves many things related to providing access to psychiatric medications for persons with serious mental illness or youth with severe emotional disturbance.

Below is a Medicaid report covering calendar year 2001 / Costs for Medicaid Eligibles with Serious Mental Illness (SMI) by Age Group, Calendar Year 2001 ("Medicaid SMI Report" July 23, 2003)

Age Group ¹	Medicaid Eligibles with SMI (Eligibility Years) ²	Costs				
		SMI Outpatient ³	Other Outpatient ³	Total Outpatient ³	All Drugs ⁴	Total
19-21	491	\$211,520	\$540,678	\$752,198	\$961,683	\$1,713,881
22+	9,829	\$5,882,331	\$8,834,716	\$14,717,047	\$42,706,791	\$57,423,838
Total	10,320	\$6,093,851	\$9,375,394	\$15,469,245	\$43,668,474	\$59,137,719

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Age Group ¹	Medicaid Eligibles with SMI (Eligibility Years) ²	Costs per Eligibility Year with SMI				
		SMI Outpatient ³	Other Outpatient ³	Total Outpatient ³	All Drugs ⁴	Total
19-21	491	\$431	\$1,101	\$1,532	\$1,959	\$3,491
22+	9,829	\$598	\$899	\$1,497	\$4,345	\$5,842
Total	10,320	\$591	\$909	\$1,499	\$4,232	\$5,731

1. Age at time of first outpatient visit (after 19th birthday) in CY 2001
2. A Medicaid Eligible was said to have SMI if he/she was at least 19 years of age and had a primary or secondary diagnosis of 295-298.9 in an outpatient setting during CY 2001
3. Costs incurred at crisis/respite care, group residential, and residential facilities are excluded
4. Cost of all prescription drugs (not only psychiatric medications)

Please note:

- the drug costs are not broken down into "psychiatric medications" and "others". The report calculates the costs for all drugs prescribed for eligibles with SMI.
- the total cost (for both outpatient services and drugs) for one person with SMI in Medicaid for one year (2001) was \$5,730.

This is from the MHPEC Strategic Planning meeting on April 12, 2002.

- "Medication Access" is an issue because:
 - there is not a stable reliable source of medications for people with mental illness.
 - no clear cut mandate on who is to pay for what. Everyone wants to be the one who pays last dollar.
- "Medication Access" Theme: Reducing the barriers to getting the right drug to the right recipient in the right dosage by the right route at the right time to consumers in community mental health settings.

There are many groups involved in this medication access issue ranging from

1. Consumers, family members
2. county level services: Counties, County Attorneys, Mental Health Commitment Boards, Sheriffs (transportation), veteran service center, county corrections
3. Service Providers: Regional Centers, Community Mental Health providers, Emergency Care Centers, Housing providers; Pharmacies, Physicians, and other health care practitioners, Nebraska Medical Association's mental health task force, Regional Governing Boards, Law enforcement, Corrections ...
4. Payers: Medicaid, Medicare, Managed Care Companies, Private insurance companies, SSI, SSDI, HHS Office of Mental Health, Substance Abuse and Addiction Services
5. Resources: Drug companies, Pharmacies ...
6. Advocates / allies: Nebraska Association of Behavioral Health Organizations (NABHO), National Alliance for the Mentally Ill-Nebraska (NAMI-NE), and Mental Health Associations of Nebraska.

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- LB 1148 (2002) PRESCRIPTION DRUG ASSISTANCE required the Health and Human Services Committee, on or before December 1, 2002, to conduct research and provide recommendations to the Nebraska Legislature and the Governor on the topic of prescription drug assistance. The bill required the committee to consult with members of the Legislature, the Governor, the Nebraska Health and Human Services System, the Department of Insurance, the Department of Revenue, political subdivisions, area agencies on aging, pharmacists, pharmaceutical manufacturers, advocates for the elderly and persons with mental illness, health care providers, insurance companies, and other interested parties.
- One source to pay for psychiatric medications is "LB95". This is an indigent outpatient, prescription medicine program administered by the Department of Health and Human Services. It is authorized under Neb. Rev. Stat. §83-380.01 (Laws 1981, LB 95, § 25). In the chart below "FY2003 Community Mental Health Funding / Office Of Mental Health, Substance Abuse And Addiction Services", note the line item "Indigent Medications" (through Regional Centers) is \$600,000 in FY2003.
- Summary on Medication Support Oriented Comments from the "ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC).
 - Many times know someone needs to get into hospital, but are not yet to the crisis level of MI & Dangerous. If not eligible for Medicaid or Medicare, it is real hard to get money for the medications. If you can get the medications you can prevent the need for the hospital bed.
 - substance abuse is self medication ... abuse and violence may come with it.
 - access to insurance company - need 20 phone call to get care ... a barrier to services
 - working poor - person is not eligible for Medicaid because they work but do not earn enough to pay for the medication. With Medicaid you can usually find someone who can take care of the individual ... the working poor need some mechanism to access the care.
 - One person testified he was on 8 different medication in last 15 years.
 - Trouble in rural NE not the same in urban NE ... shortage of psychiatrists.

Trish Blakely, Healthy Families (August 11, 2004): "It is also a tremendous problem trying to locate a psychiatrist to prescribe medication. There seems to be a very long waiting period to see a psychiatrist. Families have little selection about whom they see due to the choices available and if there is a crisis situation there is little probability that they will be able to reach a psychiatrist to get assistance. This happens over and over with families in Healthy Families Project and the Family Resource Center."

SOURCE

- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004.
- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- "Medicaid SMI Report" was prepared by Brett Foley, Statistical Analyst, Nebraska HHSS - Epidemiology; (July 23, 2003).
- Medication Accessibility discussed at the Mental Health Planning & Evaluation Council Strategic Planning Meeting - April 12th, 2002.
- Mental Health Planning & Evaluation Council June 14TH, 2002 Videoconference Meeting

- report from April 12 Strategic Planning meeting
- Jeff Santema, Legal Counsel, Health and Human Services Committee, Nebraska Legislature: Report on Legislative Interim Studies pertinent to mental health
- ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC).

GAP #7: CULTURALLY COMPETENT SERVICES

A critical service gap in the adult and children's mental health system appears to be cultural and linguistically competent services. A language barrier has arisen in several communities across Nebraska, rural and urban, due to the increase in minority populations living across the state. There is lack of access to bi-lingual mental health professionals and family support services. Services which recognize the unique cultural needs of all Nebraskans are not always available. This lack of access should be recognized and culturally competent services should be developed. The new immigrant/refugee populations in Nebraska also needs to be addressed.

Jose J. Soto said, "Despite the rapid growth of the Hispanic/Latino population in our rural communities, public sector response to the mental and behavior health service needs of that population have been slow to come and not commensurate with the growth, verified needs and often dire circumstances of this population. Included in the latter are the harsh realities of chronic poverty, the lack of adequate and stable medical care, cultural isolation, racism, and quite frequently language barriers that make available services effectively inaccessible."

source:

- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004.
- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- Jose J. Soto, Vice President for AA/Equity/Diversity, Southeast Community College Area, Lincoln, NE; July 2, 2003; e-mail to the six Regional Program Administrators
Subject: Unmet Mental Health Needs.
- December, 2001 Report: Nebraska's Public Behavioral Health System for Children and Their Families: Identification of Quantity of Services, Quality of Services, Gaps in Services and Priorities for Service Development
Nebraska Department of Health and Human Services; Region 1 Mental Health and Substance Abuse Administration; Region 2 Human Services; Region 3 Behavioral Health Services; Region 4 Behavioral Health System; Region 5 Systems; Region 6 Behavioral Health Care

Gap #8: Elderly population not being served

Another important gap is mental health services to elders.

Persons Served, All Programs / URS Table 2A FY2003 report shows that 584 (3%) are age 65+ out of a total of 19,865 served.

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

	Female	Male	Not Available	Total
65-74 years	214	131	1	346
75+ years	142	96	0	238
Total	356	227	1	584

NOTE: 19,865 - Persons Served, All Programs / URS Table 2A FY2003 report

The Profile of Persons with SMI/SED served / URS Table 14A shows 256 (2%) are age 65+ out of a total of 10,469 SMI/SED served.

Table 14A. Profile of Persons with SMI

	Female	Male	Not Available	Total
65-74 years	112	56	1	169
75+ years	52	35	0	87
Total	164	91	1	256

Note: 10,469 - Profile of Persons with SMI/SED served / URS Table 14A

Meanwhile, the Nebraska Census Data shows (FY2000) shows the people age 65-74 Years equals 115,699; age 75-84 equals 82,543; and age 85+ equals 33,953. The total age 65 years and over equals 232,195 (13.6%).

- Nebraska ranked 12th nationally in percentage of population age 65 or older.
- Nebraska ranks sixth in the nation when considering percentage of its older population in the 75-plus age group.
- The state ranks fourth nationally when considering percentage of its older population who are 85-plus.

While overall, 18.4 percent of the state's population is comprised of people 60 and older, some counties in Nebraska have much higher rates of older citizens. The counties with the highest over 60 population are Pawnee (35 percent), Webster (33 percent), Franklin (33 percent), Furnas (33 percent), Thayer (32 percent) and Hooker (32 percent).

Source:

- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004.
- Nebraska FY2003 Implementation Report URS Tables 2A and 14A
- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- web site for the Eastern Nebraska Office on Aging, Omaha, NE
- <http://www.enoa.org/demographics/index.html>
- U. S. Bureau of the Census, Census of Population, decennial, and March 2001 as reported in the "Nebraska Databook" <<http://info.neded.org/databook.php?cont=sb&ttle=Population>>

ADULT PLAN

SECTION I. Description of State Service System

- areas identified by the State in the previous State plan as needing particular attention

SECTION II Service System's Strengths, Needs and Priorities

- A statement of the State's priorities and plans to address unmet needs.

ADULT GOAL #1: BEHAVIORAL HEALTH IMPLEMENTATION PLAN

- Areas Identified In The Previous State Plan As Needing Particular Attention

This is a combination of two previous Adult Goals

- ADULT GOAL #1: STRATEGIC PLANNING - Consistent with the Governor's priority on mental health and LB 724, implement Strategic Planning to Improve the Quality and Delivery of Services provided by the Nebraska Behavioral Health System.
- ADULT GOAL #2: CONTINUE TO IMPROVE QUALITY, DELIVERY OF SERVICES AND CONSUMER ACCESS - Consistent with the Governor's priority on mental health and LB 724, continue to improve consumer access to the services provided by the Nebraska Behavioral Health System (NBHS).
 - Improve continuity of care within the requirements of HIPAA
 - For persons with serious mental illness, including transitioning young adults, develop coalitions to promote community based care under Olmstead.
 - ~ Housing
 - ~ Employment

- The State's Priorities And Plans To Address Unmet Needs.

This goal is consistent with the Governor's priority on behavioral health reform and LB 1083. Below represents a summary of key points to illustrate the work to be completed under Adult Goal #1: Behavioral Health Implementation Plan. The complete 208-page Behavioral Health Implementation Plan and other information regarding implementation of LB 1083 can be accessed at the HHSS website at <http://www.hhs.state.ne.us/beh/reform/>.

LB1083 is directing all of the planning work on Behavioral Health. HHSS will partner with the Behavioral Health Regions, community-based providers, mental health consumers, and other stakeholders to ensure that the Behavioral Health Implementation Plan is comprehensive and includes local recommendations on what services are needed. For example, as the needs of Nebraska as a whole were considered, HHSS worked diligently with the Regions to develop their Phase I recommendations.

Better use of scarce resources

Behavioral Health Reform creates new, additional funding to invest in a wider array of community-based behavioral health services. For example, by moving services from the Regional Centers into the community, it becomes possible to leverage state general funds to access approximately \$9 million in previously unavailable federal Medicaid funds.

The Behavioral Health Implementation Plan contemplates the initial infusion of an additional approximately \$48.5 million to the public behavioral health system in Nebraska as follows:

- (1) \$29 million in funding redirected from regional center services to the community;
- (2) \$9 million in additional Medicaid funding;
- (3) \$2 million in funding for rental assistance for adults with serious mental illness (administered by the NE Department of Economic Development);
- (4) \$2.5 million in funding for emergency psychiatric services; and
- (5) \$6 million in one-time funding for the statewide development of community-based services.

These one-time funds are allocated to the Regions under a separate Behavioral Health Reform contracts.

Implementation timelines and the actual amount of additional funding for the system depends on progress made in the transition of persons from Hastings Regional Center (HRC) and Norfolk Regional Center (NRC) to appropriate community-based or other regional center services. Delays in such progress will diminish the amount of available funding. The plan assumes that the Hastings Regional Center will be transitioned first. Available additional funding would be allocated to each behavioral health region based on population.

Balancing Intent, Schedule, and Budget

One of the purposes of LB1083 is to transition consumers from Regional Centers to community-based services (LB 1083 Section 2(7)). When determining the schedule for this project, the timing of moving of Regional Center appropriations plays a major part.

The vision for this project outlines the approach that will be taken to get to the Regional Center transitions specified in LB 1083.

“Consumers who need more intense levels of mental health and/or substance abuse services are served closer to their home communities, support systems, family and friends in the least restrictive environment that provides safety and protection for the individuals and the community.”

In short, the focus for accomplishing Regional Center transitions is on developing the community services that will replace the need for the State Psychiatric Hospitals at Hastings and Norfolk. To ensure that the focus remains on developing the necessary community services, dates for Regional Center transitions have not been established.

The Behavioral Health Reform focus is on people who would have been served at a state-owned Regional Center – persons committed by Mental Health Commitment Boards for involuntary treatment. Approximately 700 individuals are committed to the Hastings and Norfolk Regional Centers each year.

LB1083 Section 10 requires that appropriate community-based services be available before Regional Centers are closed. Section 10 (6) says when the Regional Centers reach 20% of their licensed psychiatric bed capacity as of March 15, 2004 (see Criterion 1, Regional Center Capacity), HHSS will notify the Legislature and the Governor. A majority vote by the Executive Board of the Legislative Council will allow for transfer of the remaining patients when appropriate community-based services are available.

The financial realities of implementing LB 1083 are that the budget to maintain the necessary community services comes from future Regional Center budgets. Thus, there is incentive to establish the community services in a time frame that creates a logical balance point between the need to transition Regional Center consumers to the community and the obligation to fund existing Regional Center services. The dates of transition depend on the Centers reaching 20% of acute/secure capacity. It is not yet known when the redirection of Regional Center funds will occur.

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Therefore, the funding allocation plan is laid out in six scenarios. These options have been prepared as part of the Implementation Plan. These examples show how the amount of funding available for the development of community based services decreases the longer services are provided in a Regional Center setting. The following chart illustrates several options for closure or redesign of the Hastings and Norfolk Regional Centers and the projected savings associated with each option.

Summary of Regional Centers Appropriation / Available for Redirection to Community-Based Services [Hastings Regional Centers (HRC) / Norfolk Regional Centers (NRC)]

	<u>SFY 2005</u>	<u>SFY 2006</u>	<u>SFY 2007*</u>
<u>Option #1</u>			
HRC savings / transition Oct 04	8,250,455	12,375,252	12,375,252
NRC savings / transition Dec 05	0	10,589,847	16,672,756
total savings	\$8,250,455	\$22,965,099	\$29,048,008
<u>Option #2</u>			
HRC savings / transition Oct 04	8,250,455	12,375,252	12,375,252
NRC savings / transition Mar 06	0	5,032,263	16,672,756
total savings	\$8,250,455	\$17,407,515	\$29,048,008
<u>Option #3</u>			
HRC savings / transition Dec 04	6,760,921	12,375,252	12,375,252
NRC savings / transition Dec 05	0	10,589,847	16,672,756
total savings	\$6,760,921	\$22,965,099	\$29,048,008
<u>Option #4</u>			
HRC savings / transition Dec 04	6,760,921	12,375,252	12,375,252
NRC savings / transition Mar 06	0	5,032,263	16,672,756
total savings	\$6,760,921	\$17,407,515	\$29,048,008
<u>Option #5</u>			
HRC savings / transition Feb 05	5,156,785	12,375,252	12,375,252
NRC savings / transition Dec 05	0	10,589,847	16,672,756
total savings	\$5,156,785	\$22,965,099	\$29,048,008
<u>Option #6</u>			
HRC savings / transition Feb 05	5,156,785	12,375,252	12,375,252
NRC savings / transition Mar 06	0	5,032,263	16,672,756
total savings	\$5,156,785	\$17,407,515	\$29,048,008

SFY = State Fiscal Year

Estimated Regional Center Appropriation

	General Funds	Federal Funds/Cash	total
Hastings Regional Center	11,049,349	1,325,903	12,375,252
Norfolk Regional Center	14,840,533	1,832,223	16,672,756
Total	\$25,889,882	\$3,158,126	\$29,048,008

Total appropriations for the three regional centers for FY 03 were \$63,396,823 (\$52,197,456 General funds; \$6,834,283 federal funds; and \$4,365,084 cash funds).

Source: Legislative Fiscal Office as reported at the Behavioral Health Oversight Commission of the Legislature, Health and Human Services Committee at Hruska Law Center, Lincoln, NE on July 9, 2004 (slide 33).

Citizens needing behavioral health services receive more appropriate care

LB 1083 will provide more appropriate services for people with behavioral health issues. Consumers will be served closer to their home communities, and live more independent lives with more support. They will be closer to their health care providers, support groups, family and friends in the least restrictive environment that still provides safety and protection for the individuals and the community.

LB 1083 addresses the lack of behavioral health services once individuals no longer need the hospital-based inpatient services provided at Regional Centers or local hospitals. The new community-based system will include many levels of services. Consumers requiring crisis stabilization will access enhanced crisis center services. Community hospitals throughout the state will be able to develop acute psychiatric inpatient and secure residential services with the capacity to have locked units and highly trained staff. Residential rehabilitation services are less restrictive and more appropriate for some persons. Other non-residential community programs can provide services and reduce re-hospitalization. Regional Center beds will stay in place for individuals with high needs, and to provide specific care, such as the sexual offender and forensic programs.

HHSS has partnered with each of the Behavioral Health Regions to ensure that appropriate community-based services are in place statewide. Community-based services may range from intensive, hospital-level care to a secure, specialized wing of a nursing home, other residential facility, or day rehabilitation program.

Because a high percentage of the commitments to the Norfolk and the Hastings Regional Centers come from Region VI, a facility is being planned for the Omaha metropolitan area. It is referred to in the plan as the Community Resource Center (CRC). The purpose of the Community Resource Center is not to substitute Regional Center beds, but to build an array of services that provide alternatives to long-term Regional Center placement, to support mental health research and to provide education to health care professionals in training. Private funding is being sought to create the CRC in either a new or an existing building. The CRC will be designed as part of a community hospital in order to be eligible for Medicaid funds.

This reform plan includes a collaborative effort between the medical centers at Creighton University and the University of Nebraska to provide behavioral health training, research, and clinical services and a program to provide professionals to serve rural Nebraska. This critical partnership will enable Nebraska to move to a prominent position as a leader in mental health service delivery and a model of statewide recovery-based services.

Stakeholder Involvement

HHSS provided information or briefings to a wide variety of individuals and organizations that have an interest in the behavioral health system. The extensive involvement of those stakeholders in planning, problem solving, and decision-making will continue as a key component of Behavioral Health Reform. Stakeholders include those individuals effecting the change, as well as those impacted by it.

- In the fall of 2001, HHSS began a process for identifying the housing needs of behavioral health consumers. With the introduction of LB 1083 HHSS expanded the involvement of consumers, providers, Regions, developers, and others in the process. Representatives of the “affordable housing” industry have been working closely with HHSS to develop strategies to address the requirements of LB 1083
- Starting with the January 18, 2001 meeting of the Mental Health Planning & Evaluation Council, Jeff Santema, Legal Counsel for the Legislature's Committee on Health and Human Services presented and received comments on various phases of the behavioral health reform initiatives. For example, on January 18, 2001, Mr. Santema did a presentation on LB682.
- Senator Jensen, Legislative staff, and representatives of HHSS met with consumers, providers, state Regional Center employees, government officials, county board, mayors, and law enforcement in September and October 2003. Meetings were held in each of the state's six regions and in the Hastings, Norfolk, and Lincoln Regional Centers.
- Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. This included the Mental Health Housing Planning Steering Committee Meetings which were held on 12/11/02, 02/07/03, 04/04/03, 05/09/03, 06/23/03, 06/26/03, 07/15/03, 08/01/03 and 10/03/03.
- November 19, 2003: in Lincoln, the Nebraska Mental Health Housing Summit was held. There were 165 participants. The primary focus was to publicly share the findings from the Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. & next steps in housing capacity development. The Governor made some opening remarks. State Senator Jim Jensen also spoke. Andrew Sperling, Director of Federal Legislative Advocacy, National Alliance for the Mentally Ill was the Keynote speaker. A special video was prepared showing interviews where consumers discuss their housing needs.
- November 19, 2003: Governor's news conference to announce behavioral health reform. Governor briefed representatives from the Hastings and Norfolk Communities and state senators that day.
- Ron Ross, former Director of HHS, met with consumers, Regional Program Administrators (RPA) and providers in all regions in November and December 2003 to discuss issues with closing Regional Centers.
- Governor Johanns met with law enforcement on December 9, 2003 and the Norfolk and Hastings communities several times throughout November and December 2003 and January 2004.
- Governor Johanns met with consumers and providers December 16, 2003, to identify and discuss their issues with the behavioral health reform.
- On January 23, 2004, HHSS met with all RPAs and law enforcement representatives to formally initiate the community planning process. HHSS provided guidelines for the planning for the development the community services necessary to treat patients needing acute and secure services in the community.

- March 2-10, 2004: Governor, HHSS and Regional Program Administrators briefed state senators on state and regional behavioral health system and behavioral health reform planning.
- From January to March Regional representatives met with consumers, Regional Center representatives, community providers, County Board members, law enforcement officials, District Attorneys, and many other stakeholders to gather input and develop community service plans necessary to implement LB 1083.
- On March 31, 2004 the six Regions presented their proposed Phase I plans to HHSS on replacing inpatient services at Hastings and Norfolk Regional Centers with community hospital services; serving persons ready for discharge from all three Regional Centers; and developing additional emergency services. Phase II plans, due December 31, 2004, will focus on long-term expansion of community-based services
- Representatives of HHSS continued the planning process in June 2004, meeting with Regions and providers to continue to collect input and to identify emerging issues.
- The extensive involvement of stakeholders in planning, problem solving, and decision making will continue as a key component of behavioral health reform. Consumers and consumer organizations, providers, law enforcement, hospitals, representatives of the legal system, county boards and other elected officials will be participants in the planning and implementation process at both the state and community level.

Behavioral Health Implementation Plan

LB1083 sections 19-20 establish important requirements on the Division preparing and submitting a Behavioral Health Implementation Plan. On July 1, 2004, HHSS submitted the LB 1083 Behavioral Health Implementation Plan to Governor Johanns and the Nebraska Legislature per sections 19-20. The complete 208-page Behavioral Health Implementation Plan and other information regarding implementation of LB 1083 can be accessed at the HHSS website at <http://www.lhs.state.ne.us/beh/reform/>. The Plan sets out:

- the approach HHSS took in planning for Behavioral Health Reform,
- the scope of the implementation plan, and
- the specific activities that HHSS will undertake to accomplish reform.

The details of the work make it clear that LB 1083 will result in more appropriate behavioral health services for people through a better use of scarce resources.

This plan focuses on two core values central to the implementing legislation:

- 1) Citizens in need of behavioral health services will receive more appropriate care; and
- 2) The new behavioral health system will make better use of scarce resources.

The HHSS recommendations for the Region Replacement Services and Funding were based on 22 Assumptions. Some of the key assumptions included:

- The priority FOCUS for all decisions is:
 - a) Replacing current capacity in HRC and NRC
 - b) Moving current NRC and HRC consumers into community housing and services
 - c) Reducing commitments, reducing emergency protective custody holds and elimination of post-commitment days in the Regions
- Decisions are based on assumption that HRC services will transition to the community first.

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- Decisions are based on timeframes and cash flow availability to move Regional Center state funds to community-based services.
- This plan does not solve all system capacity problems.
- Priority is given to less intensive services in community-based settings.
- Recommendations for discharge placements focused on least restrictive settings and assumed stable independent housing.

State Priorities

The plans and funds appropriated to the behavioral health (mental health and substance abuse) system are specifically intended to serve the adult population and to directly impact the following state priorities:

Phase I: Regional Center REPLACEMENT Services. The regions submitted plans on March 30, 2004.

Priority A – **REPLACEMENT** services to replace current HRC/NRC acute inpatient and secure subacute residential services

Priority B – **DISCHARGE READY** services for persons currently being served in the HRC/NRC/LRC

Priority C – **EMERGENCY SERVICE** development and/or restructuring to reduce EPCs and commitments in the regions.

Phase II: Expansion of Community Based Services to Impact Reduction in Need for Acute and Secure services. The regions will submit plans by December 31, 2004.

Priority A: **NON-RESIDENTIAL SERVICE** development and/or expansion to reduce use of acute inpatient and secure subacute residential services, and increase community tenure in the least restrictive setting with stable housing.

Behavioral Health Region Plans: Phase I

The first section of the Behavioral Health Implementation Plan outlines the development of services and necessary funding for each Region of the state. The six Behavioral Health Regions assessed the needs of each Region and submitted plans on March 30, 2004 to meet those needs through community-based services. The Nebraska Department of Health and Human Services System compiled and refined the regional plans to maximize resources from a statewide perspective and match the services with the specific needs of the consumers served by Regional Centers.

The funding is allocated based on the anticipated costs associated with the specific types of services needed to meet the Phase I priorities in each Region of the state. Additionally, the funding level is influenced by the average length of time a service is needed by the consumer.

Phase I priority service development and funding is as follows:

- In Region 1, the Panhandle, reliance on Regional Center care is minimal with 93% of mental health board commitments served by hospital level community based services and coordination of services provided by the Homeward Bound Project. Behavioral health services to be expanded include adding crisis response services for communities not currently

- served by Local Crisis Response Teams, increasing emergency crisis capacity and providing assisted living support services at a cost of approximately \$1.1 million dollars.
- In Region 2, west central Nebraska, reliance on Regional Center care has been moderate with all persons committed within the last 4 months served at local hospital level community based services. Local crisis response services will be expanded, as will residential services and supportive services at a cost of \$1.6 million.
 - In Region 3, south central Nebraska, reliance on Regional Center care has traditionally been heavy as the region has the highest per capita commitment rate in the state. Existing hospital-level community-based services, community residential, support services and an emergency crisis stabilization unit will be utilized to serve consumers at a cost of approximately \$4 million (including one time start up costs). This shift in services is projected to decrease commitments and increase services being provided in the community.
 - In Region 4, a large geographic area in northeast and north central Nebraska containing mainly rural/frontier counties, heavy reliance on the Norfolk Regional Center traditionally has been the case. Additional acute and secure services at the community hospital level will be developed in addition to expanding residential and support services. Furthermore, crisis stabilization to serve about 50 persons and rural crisis response teams to serve 160 persons will be developed at a cost of approximately \$3 million.
 - In Region 5, southeast Nebraska, reliance on Regional Center acute, secure, and long-term residential services for the difficult to serve population, has generally been heavy. The Region annually serves approximately 220 consumers committed to acute and/or secure services and provides emergency protective custody (EPC) involuntary crisis stabilization services to over 800 consumers. The region has 24% of the population in the state with 31% of the state's EPC cases. Approximately 30% of committed individuals come from rural Region V. In Phase I, Assertive Community Treatment (ACT) team services (capacity of 70), will be developed and directed towards consumers discharged from the Regional Centers. The emergency system will be expanded by funding rural emergency crisis response teams and emergency support services. Phase I services will cost approximately \$1.4 million.
 - In Region 6, eastern Nebraska, the development of a Community Resource Center (CRC) will be the primary focus to co-locate emergency services and acute inpatient and secure subacute services. In FY03 Region VI committed 185 people to the Norfolk Regional Centers which constituted 75% of the commitments to that facility. 48% of commitments could have been served at a secure subacute level of care that is not currently available in Region VI. The CRC will provide a twenty-four hour emergency crisis center designed to further reduce the reliance on commitments for Regional Center services. Existing services and funding will be realigned and combined with expanded funding for the CRC. The creation of an additional Assertive Community Treatment (ACT) team, serving up to 70 consumers, will provide expanded community based treatment, rehabilitation and support services for the long-term hard to serve population from the Regional Centers. Phase I services will cost approximately \$6 million.

Summary for the funding of Phase I Services / Approximate Costs in million dollars

Region	1	2	3	4	5	6	Total
	\$1.10	\$1.60	\$4.00	\$3.00	\$1.40	\$6.00	\$17.10

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Project Timeline

Apart from the timing of the Regional Center transitions, the majority of the deliverables and activities in the work breakdown structure can be scheduled. The scheduling of activities and tasks is dependent on available resources, priorities of deliverables, and dependencies between deliverables. A portion of the HHSS Behavioral Health Reform Implementation Plan / Work Breakdown Structure Deliverables Only is listed below. The complete nine page document of "Deliverables Only" can be found at

http://www.lhs.state.ne.us/beh/reform/docs/ImpPlan/WBS_Deliverables_Only.pdf

ID	Code	Subject	Status	Responsible Person	Assigned Staff
1	S5D1	S5 Deliverable 1: An Administrator for the Division of Behavioral Health Services	Due 9/30/2004		
12	S5D2	S5 Deliverable 2: A Chief Clinical Officer for the Division of Behavioral Health Services	Due 11/30/2004		
22	S5D3	S5 Deliverable 3: Office of Consumer Affairs (OCA)	Due 8/31/2004		Thomas
29	S5D4	S5 Deliverable 4: Program Administrator of Office of Consumer Affairs	Due 9/30/2004	Thomas	
39	S5D5	S5 Deliverable 5: Separate budget and method of accounting for revenues and expenditures for the Division of Behavioral Health Services	Completed	Bouwens	Pope
42	S6.1(a)D1	S6(1a) Deliverable 1: List of Rules and Regulations (R&R) for Division of Behavioral Health Services	Due 12/31/2004	Bansal	Staley
44	S6.1(a)D2	S6(1a) Deliverable 2: Operating Policies for Division of Behavioral Health Services	Due 12/31/2004	Sorensen	Thomas
51	S6.1(a)D3	S6(1a) Deliverable 3: List of existing Division provided services and locations, including Regional Centers (RC), and including brief descriptions	Due 7/31/2004	Sorensen	
56	S6.1(a)D4	S6(1a) Deliverable 4: List of proposed Division provided services and locations, including RCs, and including brief descriptions	Completed	Sorensen	
61	S6.1(a)D5	S6(1a) Deliverable 5: Roles and functions of Division of Behavioral Health Services	Due 9/30/2004	Sorensen	
67	S6.1(a)D6	S6(1a) Deliverable 6: Organizational chart for the division, including regional centers	Completed	Sorensen	
73	S6.1(b)D1	S6(1b) Deliverable 1: Integration plan	Due 12/31/2004	Sorensen	
83	S6.1(c)D1	S6(1c) Deliverable 1: Comprehensive statewide plan (Annual-not 1083 plan) [Section 10(1) has details]	Due 6/30/2005 and annually		
95	S6.1(d)D1	S6(1d) Deliverable 1: Role and functions of Regional Behavioral Health Authorities (RBHA)	Due 12/31/2004	Hanigan	Sorensen
113	S6.1(d)D2	S6(1d) Deliverable 2: Regional Budgets	Due	Sorensen	

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ID	Code	Subject	Status	Responsible Person	Assigned Staff
			6/30/2005		
126	S6.1(d)D4	S6(1d) Deliverable 4: Audit BH Programs and Services	Due 12/31/2005 and annually		
133	S6.1(e)D1	S6(1e) Deliverable 1: Management information system	Due 12/31/2005	Gamet	
141	S6.1(e)D2	S6(1e) Deliverable 2: Decision/process to "Track" patients discharged from Regional Centers (RC)	Completed	Gamet	
146	S6.1(e)D3	S6(1e) Deliverable 3: Bid and Negotiate Vendor Contract for prior authorization support	Due 6/30/2005 and annually		
150	S6.1(f)D1	S6(1f) Deliverable 1: Reimbursement Process	Due 12/31/2004		
161	S6.1(f)D4	S6(1f) Deliverable 4: Financial Eligibility policy/sliding fee scale/consumer co-pay	Due 12/31/2004		
169	S6.1(f)D5	S6(1f) Deliverable 5: Statement of Priorities	Due 9/30/2004	Sorensen	
175	S6.1(g)D1	S6(1g) Deliverable 1: List of professions, services, and facilities to be credentialed by R&L	Due 9/30/2004	Sorensen	
181	S6.1(g)D2	S6(1g) Deliverable 2: A cooperative agreement between R&L and HHS	Due 12/31/2004	Sorensen	
187	S6.1(h)D1	S6(1h) Deliverable 1: Revise cooperative agreement with F&S	Due 12/31/2004	Seiffert	Seiffert
190	S6.1(h)D2	S6(1h) Deliverable 2: List of Medicaid covered BH services	Completed	Seiffert	Brady Cygan
193	S6.1(i)D1	S6(1i) Deliverable 1: Audit Procedures	Due 12/31/2004	Wittmuss	
200	S6.1(j)D1	S6(1j) Deliverable 1: Workforce development plan	Due 7/15/2004	Shaffer	Shaffer
205	S6.1(j)D2	S6(1j) Deliverable 2: Best Practices	Due 9/30/2004	Shaffer	Shaffer
213	S6.1(j)D3	S6(1j) Deliverable 3: Clinical and educational tele-behavioral health	Due 1/31/2005		
218	S6.1(j)D4	S6(1j) Deliverable 4: Grant applications consistent with reform project	Due 12/31/2005	Shaffer	Shaffer
224	S6.1(j)D5	Section 6(1j) Deliverable 5: Training curricula	Due 12/31/2005	Shaffer	Shaffer
230	S6.2D1	S6(2) Deliverable 1: List of all regulations to be created or amended to implement LB 1083	Due 7/31/2004	Bansal	Staley
234	S8D1	S8 Deliverable 1: Guidance to RBHA to meet LB1083 requirements	Due 7/31/2004	Hanigan	Sorensen
238	S8D2	S8 Deliverable 2: HHSS provides all 6 region reports to oversight commission	Due 8/31/2004	Hanigan	Sorensen

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ID	Code	Subject	Status	Responsible Person	Assigned Staff
252	S8D3	S8 Deliverable 3: Certification of county matching funds	Due 8/31/2004	Hanigan	
257	S9D1	S9 Deliverable 1: Rules and Regulations (R&R) for the development and coordination of BH services	Due 3/31/2005		
262	S9D2	S9 Deliverable 2: R&R for the provision of BH services	Due 3/31/2005		
267	S9D3	S9 Deliverable 3: Policy for the provision of services by RBHAs	Due 12/31/2004	Hanigan	Sorensen
272	S10(1)D1	S10(1) Deliverable 1: Statewide Community BH Services Plan for July 1, 2004.	Completed	Hanigan	
311	S10(1)D2	S10(1) Deliverable 2: List of services and capacities to be provided by Regional Centers (RC).	Due 8/31/2004	Hanigan	Sorensen
325	S10(1)D3	S10(1) Deliverable 3: List of BH Services and definitions	Due 12/31/2004	Sorensen	Wittmuss
335	S10(1)D4	S10(1) Deliverable 4: Effective authorization environment	Due 12/31/2004	Sorensen	Wittmuss
343	S10(1)D5	S10(1) Deliverable 5: Quality improvement plan and process for services and transition of consumers.	Due 12/31/2005	Sorensen	
350	S10(1)D6	S10(1) Deliverable 6: Final methodology and payment rates for all BH reform services	Due 12/31/2004	Hanigan	
377	S10(1)D7	S10(1) Deliverable 7: Medicaid State Plan Amendments (SPA) or waivers as needed submitted to CMS	Due 12/31/2004	Seiffert	Brady Cygan
388	S10(1)D8	S10(1) Deliverable 8: Plan for increased supportive employment opportunity for consumers	Due 2/28/2005	Medinger	Medinger
397	S10(1)D9	S10(1) Deliverable 9: Expanded employment services for target population	Due 6/30/2005	Harvey	Harvey
399	S10(1)D10	S10(1) Deliverable 10: Regional contracts for services between state and Regions	Due 10/31/2004 and annually		
405	S10(1)D11	S10(1) Deliverable 11: Contracts or agreements with providers for services not provided through the Regions	Due 4/30/2005	Thomas	
414	S10(2)D1	S10(2) Deliverable 1: Expenditures by Regional Centers are managed so sufficient HRC/NRC funds are available to fund community services so commitments are diverted to the community.	Due 12/31/2005	Hanigan	Sorensen
433	S10(3)D1.3	S10(3) Deliverable 1.3: HHSS Criteria to make determination recommendation to Governor	Due 8/31/2004	Sorensen	
500	S10(6)D2	S10(6) Deliverable 2: Regional Center Assessment Tool	Due 7/31/2004	Shaffer	Shaffer
506	S10(6)D3	S10(6) Deliverable 3: Contracts with Transition Coordinators and Project Manager	Due 8/31/2004	Sorensen	
516	S10(6)D4	S10(6) Deliverable 4: Transition Team Trained	Due	Thomas	

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ID	Code	Subject	Status	Responsible Person	Assigned Staff
			9/30/2005		
527	S11D1	S11 Deliverable 1: Allocation plan for distribution of funds to the Regional Behavioral Health Authorities (RBHAs)	Due 7/31/2004 and annually		
533	S11D2	S11 Deliverable 2: Integrated budget	Due 3/31/2005	Bouwens	
543	S11D4	S11 Deliverable 4: Information regarding number of people served/by service/by cost	Due 9/30/2004	Sorensen, Hanigan Division	
546	S13-16D1	S13-16 Deliverable 1: Recommendation on committee members for State Advisory Committees on Mental Health Services, Substance Abuse Services, and Problem Gambling and Addiction Services	Completed	Sorensen	
551	S13-16D2	S13-16 Deliverable 2: Draft document of by-laws	Due 10/31/04	Sorensen	
556	S13-16D3	S13-16 Deliverable 3: List of staff assigned to support council and committees	Completed	Sorensen	
558	S13-16D4	S13-16 Deliverable 4: Organization meeting arrangements (BH Council and subcommittees)	Due 10/31/04	Sorensen	
584	S21D1	S21 Deliverable 1: Training Packages	Due 8/15/2004	Thomas	
596	S21D2	S21 Deliverable 2: Consumer group input to develop training - Section 36(1)	Due 8/15/2004	Sorensen Thomas	
598	S101D1	Section 101 Deliverable 1: System for matching SMI Consumers in Independent Housing (consumer/provider/landlord)	Due 12/31/2004	Harvey	
606	S101D2	Section 101 Deliverable 2: Recommendations to DED	Completed	Harvey	
616	S101D3	Section 101 Deliverable 3: Housing First Policy	Due 6/30/2005	Harvey	

ADULT GOAL #2: EMPOWER CONSUMERS

Each goal will address

- Areas Identified In The Previous State Plan As Needing Particular Attention
- The State's Priorities And Plans To Address Unmet Needs.

- Areas Identified In The Previous State Plan As Needing Particular Attention

In the FY2004 application, this was presented as "ADULT GOAL #3: EMPOWER CONSUMERS".

- The State's Priorities And Plans To Address Unmet Needs.

The Nebraska Behavioral Health Services Act (LB1083; Approved by the Governor April 14, 2004) now makes this consumer role a formal component within HHS. Within the new Division

of Behavioral Health Services, there will be an Office of Consumer Affairs. Specifically, Nebraska Behavioral Health Services Act authorizes the following:

Section 5.(2) includes the following:

- The Director shall appoint ... a Program Administrator for Consumer Affairs for the Division.
- The Program Administrator for Consumer Affairs shall be a consumer or former consumer of Behavioral Health services and shall have specialized knowledge, experience, or expertise relating to consumer-directed Behavioral Health services, Behavioral Health delivery systems, and advocacy on behalf of consumers of Behavioral Health services and their families.
- The Program Administrator for Consumer Affairs shall report to the Administrator of the Division.

Section 5. (3) The Administrator of the Division shall establish and maintain an Office of Consumer Affairs within the Division. The Program Administrator for Consumer Affairs shall be responsible for the administration and management of the office.

On August 16, 2004, Senator Jim Jensen released the schedule for the Mental Health Consumer Forums. The consumer information and input forums have been scheduled in each Behavioral Health Region. The forums are sponsored by the Health and Human Services Committee and Behavioral Health Oversight Commission of the Nebraska Legislature, and the Nebraska Health and Human Services System in cooperation with the state's six Regional Behavioral Health Authorities. "We want to provide information to consumers about LB 1083 and implementation of behavioral health reform, including establishment of a new state Office of Consumer Affairs," said Senator Jim Jensen. "More importantly, we want to get input and suggestions from consumers themselves." While Senator Jensen will not be able to attend the forums, staff of the Health and Human Services Committee will be present to address questions and concerns. The dates, times and locations for the forums are as follows:

- August 23 (Mon) 9:00 – 11:00 am Goodwill Industries, Grand Island
- August 23 (Mon) 2:00 – 4:00 pm SE Community College, Lincoln
- August 24 (Tues) 10:00 – 12:00 Omaha Public Schools TAC Building
- August 26 (Th) 9:00 – 11:00 am Gering Civic Center, Scottsbluff
- August 26 (Th) 3:00 – 5:00 pm Frontier House, North Platte
- August 27 (Fri) 10:00 – 1:00 pm Lifelong Learning Center, Norfolk

"Real Choice" Grant

HHSS was awarded a three-year federal grant from the Centers for Medicare and Medicaid Services (CMS) for the opportunity to review and make significant improvements to the long-term care service delivery systems. Nebraska refers to its effort as "Real Choice for Nebraskans." Under the "Real Choice" grant, HHSS has targeted its long-term care programs that serve the aging population; as well as programs that serve both children and adults with developmental disabilities, physical disabilities, behavioral health needs, and medically-complex conditions. Many of these programs currently operate in isolation of one another, even though consumers often need services across programs. It is for this reason that Nebraska proposes to undertake its

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systems' change grant by redirecting its philosophy of service delivery to one that is based on consumer need rather than defined by populations and funding streams.

Consumer Liaisons

The Office of Mental Health, Substance Abuse and Addiction Services has employed two consumers for over 12 years. Initially, these consumers were part time employees. In 1998, they were converted to full-time employees. The two full-time Consumer Liaisons on staff are Dan Powers and Phyllis McCaul. Overall, the consumer liaisons continue working as change agents and advocates as staff members within the Nebraska Department of Health and Human Services. Their leadership both within the Office and in community settings changes the dynamics of a meeting, with consumer concerns being addressed more consistently. Thus, in effect, this has operated as an Office of Consumer Affairs. Now, the new legislation formalizes it and gives more formal direction to the inclusion of substance abuse and gambling consumers.

FUNDING: The Office of Mental Health, Substance Abuse and Addiction Services allocates **\$305,684** annually on consumer empowerment oriented activities. This includes funding the two full-time Consumer Program Specialist (known as Consumer Liaisons) on staff as well as the Annual Consumer Conference (for about 125 mental health consumers). Annually the HHS funds a consumer conference designed to educate consumers in mental health issues and to speak up to national, state and local mental health officials to advocate on their and the systems behalf. The funding source for the consumer liaisons started as the five percent (5%) state administrative portion of the Community Mental Health Services (CMHS) Block Grant. In FY2004, the administrative portion is \$105,299 (5% of \$2,105,983).

The Budget for Consumer Activities in FY 2005

Revenues

MH Block Grant 5% admin	\$105,299
MH Block Grant purchase of service	\$60,000
State Funds	\$140,385
Total	\$305,684

Expenditures

State Consumer Initiatives Contracts

- | | |
|---|----------|
| (1) National Alliance for the Mentally Ill –Nebraska - The Office contracts with the National Alliance for the Mentally Ill -Nebraska to ensure a state organizational structure is available for consumers. It will also conduct consumer sensitivity training for administrative and front line staff of mental health and substance abuse providers. | \$47,750 |
| (2) League of Human Dignity - This contract is used to fund cash advances and reimbursements to consumers in order to help people attend meetings, workgroups and conferences. | \$10,000 |
| (3) Mental Health Association of Nebraska - The Office contracts with the Mental Health Association to ensure a state organizational structure is available for consumers and provide consumer sensitivity training to administrative and front line staff in Nebraska nursing homes and assisted living facilities | \$47,750 |

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(4) Partners in Recovery – for substance abuse consumers	\$4,885	
(5) Each region gets \$5,000 for Family Organizations – The Office partners with HHS Protection and Safety to fund family organizations to provide family mentoring services to families of SED Children. A Family Organization is funded in each region. The Office provides \$5,000 per Region. +	\$30,000	
State Funds		\$140,385
(1) Peer Specialists - Goes to the Regions to pay for employees in Day Support who are peer specialists. *	\$60,000	
(2) Two Consumer Liaisons & Annual Consumer Conference **	\$105,299	

Federal MH Block Grant on Consumer Empowerment	\$165,299
Total Annually on Consumer Empowerment Oriented Activities.	\$305,684

* Federal MH Block Grant aid funds - not administrative set aside

** Federal MH Block Grant administrative funds portion is \$105,299 (5% of \$2,105,983).

+ NOTE: In FY2005 TOTAL CONTRACT WORTH \$260,000

Office of Protection and Safety (\$230,000)

Office of Mental Health, Substance Abuse and Addiction Services (\$30,000)

The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services offered a proposal to solicit bids for a new support activity called "Families Mentoring & Supporting Other Families", a joint initiative.

WEB SITE: The Nebraska Department of Health and Human Services web site provides a summary on how to contact the Consumer Liaisons. Go to the HHS web site and click on "Behavioral Health". <http://www.hhs.state.ne.us/beh/behindex.htm>

- Click on: Citizen Advocacy and Planning Groups
- Click on: Mental Health Consumer Advocacy
- You will arrive at <<http://www.hhs.state.ne.us/beh/mh/mhadvo.htm>> On the "Mental Health Consumer Advocacy" web site there are links to national and state mental health advocacy groups.

AREAS OF WORK

This is a brief list of the areas the two Consumer Liaisons address:

- Mental Health Consumer Advocacy
- Annual Consumer Conference
- Advisors on HHS Community Mental Health Policy
- Promote the development of Peer Specialists
- Advisory Panel for the "Evaluability Assessment for an Evaluation of the SAMSHA/CMHS Mental Health Block Grant Program." Dan Powers is a member of this Advisory Committee and has participated in its discussions
- Grant Reviewer Statewide Consumer Network Grant, SAMSHA. Dan Powers participated as a reviewer.
- Projects for Assistance in Transition from Homelessness (PATH) Dan Powers is the State PATH contact.
- Participate in the Consumer/Survivor Mental Health Administrators organization

- Co-Coordinate the annual Board of Mental Health Training
- Substance Abuse Consumers
- Consumer Satisfaction Program Visits
- Consumer Mailing List developed and maintained

ADULT GOAL #3: SUICIDE PREVENTION INITIATIVE

- Areas Identified In The Previous State Plan As Needing Particular Attention
- The State's Priorities And Plans To Address Unmet Needs.

- Areas Identified In The Previous State Plan As Needing Particular Attention

In the FY2004 application, this was presented as "ADULT GOAL #4: SUICIDE PREVENTION INITIATIVE".

- The State's Priorities And Plans To Address Unmet Needs.

The Nebraska Statewide Suicide Prevention Initiative Committee continues to meet regularly to update and revise goals and objectives for Nebraska's suicide plan. No additional funding has been specifically budgeted or accessed for suicide planning or support of state activities.

An innovative suicide prevention program being used by the State Juvenile Detention facilities was highlighted in a poster session both at the Regional SPRC (Suicide Prevention Resource Center)/SAMSHA sponsored Region VII & VIII Conference in Colorado that took place October 28-30, 2003. The program highlighted, "The Green Line," was developed by Dr. Don Belau. As a result of this poster presentation he was invited to present a paper at the April 2004 American Association of Suicidology Conference in Miami, Florida. Two other Nebraska presenters were also featured at the Region VII and VII Colorado Conference.

The Southeast Nebraska Suicide Prevention Curricula continues to be disseminated. The core curriculum was presented by mental health consumers at the Nebraska Alliance for the Mentally Ill State Conference in 2004. It has been available for download through the University of Nebraska Public Policy Center's faith initiative site (www.nebhands.nebraska.edu) ... Click on "Resources". On that web page "Resources to Assist and Answer Questions", click on "Suicide Prevention Curriculum". It was distributed to faith based and community organizations via hard copy and cd-rom through that organization. Additionally, the curriculum was distributed to a national audience at the 2004 Christian Unity Conference in Omaha, Nebraska. The curriculum was sent to Dr. David Litts of the SPRC in 2004 for use a model of public domain educational material that can be rapidly and widely disseminated and used by different groups. Additionally, the clergy module of the Southeast Nebraska Suicide Prevention Curriculum contained eulogy recommendations that were piloted for the SPRC. The evaluation data from these participants are now being analyzed in preparation for the release of the recommendations. The Law Enforcement Module has been fully integrated with the Nebraska Law Enforcement Training Academy and is now a standard part of the training that Law Enforcement recruits receive in the state of Nebraska. The health care module has been translated into video format for easy viewing by health care personnel and is a standard part of the yearly training required by at least one of the major hospitals in Nebraska (BryanLGH Medical Center). It is also regularly presented to hospitals that are part of the Heartland Health Alliance across Nebraska.

The Community Mental Health Center of Lancaster County obtained certification from the American Association of Suicidology as a Crisis Center in 2003. They are working toward participation in the Hopeline Network as a 1-800-suicide hotline resource. The other certified hotline in Nebraska is located at Boys & Girls Town in Omaha.

The state committee participated in the development of Nebraska's injury prevention planning in the area of suicide prevention in 2004. The committee will have a regular presence in 2004 with the health department advisory group that includes planning for intentional self harm and youth prevention efforts.

What's next?

The goals for the State Suicide Prevention Committee include supporting ongoing state wide efforts to de-stigmatize mental health and seeking help through support of "Project Relate" – a public relations campaign sponsored by a number of organizations including the Kim Foundation and Omaha Federation of Advertising, NAMI, and a number of health care providers.

(www.projectrelate.org) No direct state funding is anticipated for the next few years in this area, so the committee will focus on supporting private efforts and finding innovative ways to create awareness and participate in research while furthering best practices.

Nebraska is in the midst of a behavioral health reform project that will create exciting new opportunities for further dissemination of suicide prevention information to communities in the coming months. It is anticipated that there will be an increased role for Nebraska's prevention networks in this effort.

ADULT'S PLAN

Federal Requirements

PART C. State Plan

Section III. Performance Goals and Action Plans to Improve the Service System

a) Adult Plan (Current Activities / Goals, Targets and Action Plans)

- i. Comprehensive community-based mental health services
- ii. Mental health system data epidemiology
- iii. Not applicable
- iv. Targeted services to rural and homeless populations
- v. Management systems

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:
 - Health, mental health, and rehabilitation services;

- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization.

(i) Current Activities

Organizational Structure for the System of Care:

Nebraska Behavioral Health Services Act (LB 1083) establishes the framework for the provision of behavioral health services.

- Under Section 3 the purposes of the Public Behavioral Health System are to ensure:
 - (1) The public safety and the health and safety of persons with Behavioral Health disorders;
 - (2) Statewide access to Behavioral Health services
 - (3) High quality Behavioral Health services
 - (4) Cost-effective Behavioral Health services
- Under Section 4. (2) Behavioral Health disorder means mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder.
- Under Sections 7-9, the six Regional Behavioral Health Authorities are established.

LB1083 Section 6 (1) says the Division shall act as the chief Behavioral Health authority for the State of Nebraska. The Office of Mental Health, Substance Abuse and Addiction Services is located within the Division of Behavioral Health Services. HHS contracts with the six Regional Behavioral Health Authorities established under LB1083 Sections 7-9 to purchase community mental health services. State and federal community mental health funds are allocated to the RBHAs by contract for service delivery at the local level. The RBHAs contract with public and/or private service agencies or individuals to provide services in their regions or assume direct responsibility for the provision of community-based services. A further description of the State's community-based system of care is provided in Section II of this application.

A description of health medical, dental, employment and educational services that support adults with SMI in the community.

In order to enable individuals with Serious Mental Illness (SMI) to function outside of inpatient or residential institutions to the maximum extent of their capabilities, the "Community Support Mental Health" service provides linkages, referrals and coordination of necessary services and supports as identified in the Individual Service Plan (ISP) to ensure consumer recovery, including, but not limited to: **rehabilitation services; employment services; housing services; (Residential and Transitional Residential), educational services; substance abuse services; medical and dental services; support services; case management services;** and other activities to help reduce psychiatric hospitalization.

The Office of Mental Health, Substance Abuse and Addiction Services has the responsibility to ensure that the community mental health, substance abuse, and gambling assistance services needed by Nebraskans are available and accessible in Nebraska. Here is an overview:

- The General Mental Health Services array includes specialized mental health treatment services that have a primary acute care mission. The main focus of these services is appropriate diagnosis and the amelioration of symptoms through effective treatment. For the most part, mental health services delivered through these service options are short-term and time-limited.
- The Psychiatric Rehabilitation and Support array is composed of specialized mental health services that have a primary psychiatric rehabilitation and support mission. Here the main focus shifts from illness to disability with the goal of providing the support necessary for the individual to live in the least restrictive setting. These services also focus on rehabilitative interventions that allow the consumer to overcome or maximally compensate for the deficits produced by mental illness. The Psychiatric Rehabilitation and Support Array, in contrast to the General Mental Health Services array, is composed of long-term services that assume the need for consistent (at least once per week) involvement with one or more of the Rehabilitation and Support services over a long period of time (months or years).

Description and Definition of the State's Case Management System:

In Nebraska, case management services are part of the service referred to as “Community Support”. A description of the Community Support Mental Health-Adult is

1. The Mental Health Community Support program is for persons disabled by severe and persistent mental illness.
2. This service is designed to provide direct face to face contact with consumers to develop skills necessary to live as independent a life in the community as the consumer is able.
3. Emphasis is on an active rehabilitation plan addressing all functional deficits.
4. Ancillary services include **case management** and advocacy.

Please note item 4 includes **case management**. Items 1-3 go far beyond that.

The service is provided to adults with serious mental illness in need of intensive in-home and in-community services. The intent of the service is to increase independent living skills, enhance quality of life, and decrease the frequency and duration of hospitalization by linking the consumer to appropriate service providers, providing rehabilitative/support services and monitoring service provision of other allied service providers. Community Support occurs on an ongoing basis at the individual's place of residence or other locations as specified in the consumers Individual Service Plan (ISP). The community support program provides a clear focus of accountability for meeting the consumer's needs within the resources available in the community. The role(s) of the community support provider may vary based on consumer's needs. Community support is an in-vivo service with most contacts typically occurring outside the program office i.e., in the consumer's place of residence or other community locations consistent with individual consumer choice/need. The contact frequency is individualized and adjusted in accordance with the level of rehabilitation and support needed by the individual.

Services For Individuals Diagnosed with Both Mental Illness and Substance Abuse

One expectation of Behavioral Health providers in Nebraska is that they should have arrangements to assess the need for mental health and substance abuse services among clients of

the agency. Upon recognition, the provider makes suitable arrangements available to the client either through referral or as a part of the program activities. An ongoing requirement in service definitions since 1998 includes all of primary mental health treatment services screen for substance abuse and seek consultation for further evaluation. All of the primary substance abuse treatment services screen for mental illness and seek consultation for further evaluation.

Official state definitions on services for individuals diagnosed with both mental illness and substance abuse include:

- (a) Dual Disorder: an adult with a primary severe and persistent mental illness AND a primary chemical dependency disorder. An adolescent with a primary severe emotional disturbance and a primary chemical dependency (or diagnosed entrenched dependency pattern).
- (b) Dual Disorder Treatment: dual disorder services provide primary integrated treatment simultaneously to persons with an Axis I chemical dependency AND an Axis I major mental illness. Clients serviced exhibit more unstable or disabling co-occurring substance dependence and serious and persistent mental illness disorders. The typical client is unstable or disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in addictions treatment. Providers of Dual disorder treatment programs demonstrate a philosophy of integrate treatment in treatment plans, program plans, staffing, and services provided. Both disorders are treated as equally primary. Appropriate licensed and certified staff including staff with addiction certification is required to provide treatment.
- (c) Dual Enhanced Treatment: a service for persons whose mental illness or substance disorder is less active than the primary diagnosis. Providers of these treatment services may elect to enhance their primary service to address the client's other relative stable diagnostic or sub-diagnostic co-occurring disorder. The primary focus of such programs is mental health or addictions treatment rather than dual diagnosis concerns and is not a primary, integrated dual disorder treatment.

A new Dual Disorder Treatment program that meets this state definition for dual treatment was developed in Region 4 in early 2002 with the new/expanded tobacco funds. The Well Link in Norfolk just developed a Dual Residential program for women with SPMI and CD only and is funded with both MH Tobacco funds and SA Tobacco funds.

Mental Health Service Definitions (Services Funded through the Division and the Regions)

MENTAL HEALTH EMERGENCY

24-Hour Crisis Line – Telephone access 24-hours/day, 7 days a week to staff trained in Mental Health support with access to Mental Health Professionals.

Mobile Crisis – A two-person team offers on-site services assessment and crisis stabilization for individuals experiencing a mental health crisis; includes access to trained mental health staff, 24-hours/7days per week to provide interventions and/or screenings.

Crisis Respite – 24-hour short-term residential care typically for no more than 3 days for individuals with a severe and persistent mental illness needing supervised assistance to stabilize on their medications or get back on their medications.

Emergency Community Support – Aftercare service for individuals who have received Emergency Services; includes service identification, ensure arrangement and attendance at services, coordination of a care plan, provide or arrange for transportation, assist with housing, and direct support for teaching activities of daily living to keep someone out of the hospital. This service may begin until longer-term community support is available in the home community. The emergency community support averages no more than 120 days.

Crisis MH Assessment (see Crisis Center) – A thorough mental health assessment/evaluation completed by a psychiatrist for persons admitted to a Crisis Center on an EPC involuntary hold to determine mental illness diagnosis, dangerousness, and recommended service level. An evaluation for the Emergency Protective Custody (EPC) hold is completed within 36 hours to determine if further action should be taken.

Crisis Center (EPC) – 24-hour medical facility that can provide emergency care to stabilize a person on an EPC hold who is alleged to be mentally ill and dangerousness and/or chemically dependent and dangerousness.. The county attorney makes a decision within 72 hours whether to request a hearing to involuntarily require someone to receive appropriate mental health and/or substance abuse services. An EPC hold can be dropped after the evaluation if no mental illness or chemical dependency is found, or if the person agrees to voluntarily seek treatment. A commitment hearing must be held within 7 days of admission.

MENTAL HEALTH RESIDENTIAL

Residential Rehabilitation (Psych Res Rehab) – 24 hour, residential facility in the community for persons with severe and persistent mental illness. Persons in this service need the 24-hour structured psychosocial rehabilitation and medication management to regain or relearn skills that will allow them to live independently in their communities. Length of service varies depending on individual needs but is not longer than 4-8 months. Length of service varies depending on individual needs but is usually not longer than 9-18 months.

Dual Residential -- Facility based program that provides simultaneous integrated treatment for individuals with severe and persistent mental illness and chemical dependence. Includes medication management and psychosocial rehab as well as treatment for stabilization and recovery. Substance abuse and mental health professionals staff the service. Substance abuse and mental health treatment are integrated. Length of service varies depending on individual needs but is not longer than 4-8 months.

MENTAL HEALTH NON-RESIDENTIAL

Assertive Community Treatment – Self-contained ten-member clinical team which assumes responsibility for directly providing comprehensive treatment, rehabilitation and support services to eligible consumers with severe and persistent mental illness. Often termed a “hospital without walls”, it allows for a team of professionals to be responsible for whatever it takes to keep someone out of the hospital. A team leader, psychiatrist, nurses, licensed mental health practitioner, certified substance abuse counselor, vocational specialist, peer specialist and other mental health professionals are full time members of the team. Because of the lack of psychiatrists and other clinically trained professionals on the team, this team approach to service provision has limited applicability in rural areas. Duration of this service is as needed to achieve stability in the functional deficit areas.

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Day Treatment – Specialized medically based day program for persons with serious mental illness that enables a person to live independently and still attends an intensive program including assessment, individual, family and group therapy, and medication services as developed by a multidisciplinary team. Programming usually involves 6-8 hours of activity per day/6-7 days per week. Length of service varies depending on individual needs but is usually not longer than 21-45 days.

Day Rehabilitation – Facility based day program for a person with severe and persistent mental illness that focuses on psychosocial rehabilitation after treatment has stabilized the mental illness. Provides prevocational and transitional employment services, planned socialization, skill training in activities of daily living, medication management, and recreation activities are focused on returning a person to work and maintaining independence in the community. Programming usually involves 5 hours of activity per day/5 days per week and some weekends. Length of service varies depending on individual needs but is usually not longer than 6 months – 5 years.

Vocational Rehabilitation – Job coaching and supported employment funded through the Division of Vocational Rehabilitation with matching funds from the NBHS system. Services are provided to persons with severe and persistent mental illness.

Community Support – With 24 hour, 7-day/week availability, provides consumer advocacy, ensures continuity of care, active support in time of crisis, provides direct skill training in the residence and community, provide or arrange for transportation, arrange for housing, acquisition of resources and assistance in community integration for individuals with severe and persistent mental illness. Length of service varies depending on individual needs but is usually not longer than 6 months – 2 years.

Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for a variety of mental health problems which disrupt individual's life that includes counseling and talk therapy treatment to change behavior, modify thought patterns, cope with problems, improve functioning; may include coordination to other services to achieve successful outcomes. Length of service varies depends on individual illness and response to treatment but averages 10 sessions at least once per week. Group therapy sessions include approximately 3-8 persons. Family counseling are included in this service level.

Psychological Testing – Psychological and diagnostic tests completed by a licensed, clinical psychologist.

Medication Management – Prescription of appropriate psychotropic medication (usually, but not limited to persons with severe and persistent mental illness), and follow-up to therapeutic response, including identification of side effects. Medication checks usually take 15-30 minutes with the psychiatrist, an/or a nurse or case manager.

Vocational Support – Ongoing support for persons with severe and persistent mental illness after they have secured long term employment. The support activities general take place off the job site, but can include assistance in learning job duties, problem solving and other job functions in order for individual to maintain gainful employment. Length of service depends on individual consumer need but is usually not longer than 6-24 months.

Day Support (Drop-In Center w/Peer Support) -- Facility based program for persons with severe and persistent mental illness. This transition “drop-in” center for persons who have not yet enrolled in Day Rehabilitation, or who have completed their rehab plan in the Day Rehab service and want to continue to socialize with friends they have made at the Day Rehab

service is designed to engage consumers. This service does not require a service plan but provides an environment to be with other people who share the same life and illness situation. Persons with severe and persistent mental illness are hired as peer specialist staff in this program. Additional support including outreach are the main focus of this drop in center. Pre-Day Rehab consumer length of stay may be 3-6 months. Post-Day Rehab consumer length of service is very individualized and may range from 6 months – 5+ years. Care Monitoring (MH) -- Ongoing support case management service for persons who no longer need the active rehabilitation service of Community Support. Length of service depends on individual consumer need with documented client contact of no more than one time per month in person or by phone.

Fee-For-Service or Non-Fee

Nebraska pays public providers either on a fee-for-service or non-fee basis.

- **Register** – Non-fee basis is an expense reimbursement system. Agencies are paid up to a maximum stated in a contract for the purpose of operating a program or service type.
- **Authorize** – Fee-for-service is Nebraska's managed care system and is a payment system based on units of service.

Units are paid for a person and are based on fees set by the State, or RBHA and the private non-profit entity providing the service. An individual receiving services paid for on a fee-for-service basis, must have the service authorized by Magellan Behavioral Health Care, Inc. -- The Nebraska public, community-based system, managed care administrative service organization. The tables below provide a listing of the Nebraska behavioral health service names. For more information see: <<http://www.hhs.state.ne.us/beh/bhsvcdef.htm>>

Authorized services include Community Support services (Mental Health, Substance Abuse), Assertive Community Treatment (ACT), Acute Inpatient, Secure Residential – MH, Intermediate Residential – MH, Intermediate Residential – SA, Psych Residential Rehabilitation – MH, Short-Term Residential – SA, Halfway House – SA, Dual Residential, Therapeutic Community – SA, Day Treatment – MH, Partial Care – SA, Intensive Outpatient – MH, Intensive Outpatient – SA, Day Rehabilitation – MH, and Vocational Rehabilitation. Care Monitoring may be either authorized or registered.

Register services include Emergency 24 hour Clinician on-call / phone, Crisis Assessment/Evaluation, Mobile Crisis Intervention, Emergency Shelter –Social Detox, Emergency Shelter –Psych Respite, Emergency Community Support, Emergency Protective Custody, Civil Protective Custody, Emergency Shelter –Residential Stabilization, Outpatient Assessment/Therapy – MH, Outpatient Assessment/Therapy – SA, Psychological Testing, Medication Management – MH, Medication Management – SA Methadone, Day Support, and Vocational Support – MH.

Nebraska Regional Center Capacity

The state has three regional centers (state hospitals for the mentally ill), located in Hastings, Lincoln, and Norfolk, which are operated by the Department of Health and Human Services.

Hastings Regional Center, Hastings, NE (HRC)

Licensed Beds as of 3/23/04

Psychiatric Hospital License – 126 beds, of which 112 are certified for Medicare

- 14 of these are Sexual Offender beds
- **112 of these are Adult Acute beds+**

Mental Health Center License – 28 beds (Residential beds)

Substance Abuse Treatment Center License – 75 beds (Adolescent beds)

HRC Total Beds: 229

HASTINGS REGIONAL CENTER / Non-Residential MH / Outpatient Services

- ACT - capacity of 72
- Mental health center – 200 clients currently enrolled

Lincoln Regional Center, Lincoln NE (LRC)

Licensed Beds as of 3/23/04

Psychiatric Hospital License - 210 beds, of which 91 are certified for Medicare

- 6 of these beds are Adolescents beds
- 119 of these are Forensic / Sexual Offender beds
- **85 of these are for Short Term Care / Community Transition Program beds (Adult Acute)+**

Mental Health Center Licenses – 57 beds (Located on Lincoln Regional Center Campus)

- 40 Adolescent Beds
- 17 Sexual Offender Beds
- 24 Adolescent Beds on Whitehall Campus (Located at 5801 Walker Ave, Lincoln, NE)

LRC Total Beds: 291

Lincoln Regional Center Non-Residential Mental Health / Outpatient Services

- * Adolescent competency evaluation services (12 per year estimated)
- * Adult Aftercare Sex Offender Services – 24 patients enrolled
- * Adult Psychiatric Forensic Evaluations – 20 evaluations annually
- * Adult Community Transition Program Outpatient Visits / 15 minute medication check – by LRC Psychiatrist 119 visits annually
- * Wagon Wheel Industrial Center (used by inpatient & outpatient) 18 average daily census
- * LB95 patients / outpatient services, about 170 patients.
- * Short Term Care Outpatient Dual Diagnosis Program is a bridge between LRC and community placement/services.

Norfolk Regional Center, Norfolk, NE (NRC)

Licensed Beds as of 3/23/04

Psychiatric Hospital License – 208 beds, of which 107 are certified for Medicare

- **All 208 are Adult Acute beds+**

NRC Total Beds: 208

NORFOLK REGIONAL CENTER / Non-Residential Mental Health

- * Day Treatment / Partial Hospitalization Average Daily Census = 10

* Out-patient / Medication Management – total of 160 patients.

- 80 patients in the outpatient program

- 80 patients in the LB 95 program

* Note: Some of the patients may be in both programs but are only registered in one or the other because the AIMS system can only have a patient in one program at a time.

NOTE: The Federal Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). All three Regional Centers hold CLIA Waiver Certificates which means they are each authorized to do laboratory tests including such things as blood glucose and urine dip stick tests. A complete list of tests that fall with these categories can be provided in hardcopy form or may be accessed at www.cms.gov/clia/ (Approved Waived Test List).

Also NOTE: The capacities listed above are for Licensed beds as of 3/23/04.

Capacity is also determined by staffed beds. Total = 347

- HRC: Staffed for 84 acute adult beds

- LRC: Staffed for 83 acute adult beds

- NRC: Staffed for 180 acute adult beds

This is the number being used in the "Nebraska Behavioral Health Services Act" (LB1083), Section 10. (6) "When the occupancy of the licensed psychiatric hospital beds of any Regional Center reaches twenty percent or less of its licensed psychiatric hospital bed capacity on March 15, 2004, the Division shall notify the Governor and the Legislature of such fact."

HRC 112 Adult Acute beds

NRC 208 Adult Acute beds

LRC 85 Adult Acute (Short Term Care / Community Transition Program beds)

On August 13, 2004, Richard Raymond, M.D., Chief Medical Officer announced that the HHS System is reducing acute inpatient beds and increasing residential beds at the Hastings Regional Center.

- The Hastings Regional Center has 126 licensed Psychiatric Hospital or adult acute beds. The number of licensed Psychiatric Hospital beds will be reduced from 126 to 30 beds to better reflect current occupancy and staffing. Fourteen of these are occupied by sexual offenders and will be left as is at this time. The remaining 16 will remain licensed as Psychiatric Hospital beds.
- The Hastings Regional Center will also increase the number of licensed Mental Health Center or residential beds from 28 to 40 beds. The increased residential beds will provide transitional services at HRC for individuals hospitalized at community hospitals or at the Lincoln and Norfolk Regional Centers who have improved enough to no longer require acute/secure hospitalization, but who are not yet ready for discharge to the community.
- the Juvenile Chemical Dependency Program at HRC was being expanded from 28 to 40 beds to meet the increasing need for youth chemical dependency treatment.

So, when fully implemented, the net result here would show the revised Hastings Regional Center staffed bed capacity to be:

- 30 adult acute beds
 - 40 beds residential beds
 - 40 beds Juvenile Chemical Dependency Program at HRC
- 110 beds total

(ii) Goals, Targets and Action Plans

Criterion 1: Comprehensive Community- based Mental Health Service Systems

GOAL: Maintain capacity of Community Support Services (2004)

FY 2005 Nebraska MENTAL HEALTH PLAN

Criterion 1: Comprehensive Community- based Mental Health Service Systems

GOAL: Increase capacity of Community Support Services

OBJECTIVE: In light of current Behavioral Health Reform, by June 30, 2005, the number of persons served with Serious Mental Illness receiving Mental Health Community Support Services will be increased.

POPULATION: SMI Adults

Performance Indicator	FY2003 Actual	FY2004 Projected	FY2004 Actual	FY2005 Target
Value:	2,613	2,600		3,000

Number of persons SMI who are receiving Mental Health Community Support (including case management) services

Value = all persons reported SMI receiving Mental Health Community Support

Data source: from Nebraska Division of Behavioral Health Services

Criterion 2: Mental Health System Data Epidemiology

Criterion 2: Mental Health System Data Epidemiology

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

(i) Current Activities

The Nebraska Databook reports the state's population in 2003 is 1,739,291.

(see <<http://info.neded.org/databook.php>>).

Nebraska Statewide by Race

Total	White	Black	American Indian, Eskimo or Aleut	Asian or Pacific Islander	Hispanic Origin ¹	Other Races ²
1,711,263	1,533,261	68,541	14,896	22,767	94,425	71,798
100.0%	89.6%	4.0%	0.9%	1.3%	5.5%	4.2%

Nebraska Statewide by Sex

Male	843,351	49%
Female	867,912	51%
TOTAL	1,711,263	100%

Source: Last Updated: 2/26/02 By Nebraska Databook -

<http://info.neded.org/stathand/bsect8.htm>

Based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001.

Metropolitan Statistical Areas (MSA) 50,000 or more

In Nebraska there are six counties designated as “Metropolitan Statistical Areas” by the U.S. Census Bureau. These counties are

Region VI – Douglas (includes City of Omaha / 390,007), Sarpy, Cass, Washington,

Region V – Lancaster (includes City of Lincoln / 225,581),

Region IV – Dakota county (includes South Sioux City / 11,925) connected to Sioux City, Iowa.

SARPY County includes Offutt Air Force Base in the Omaha, NE—IA MSA.

More than half of Nebraska’s population now lives in metropolitan areas. As of 2000, the Nebraska portion of the “Omaha, NE—IA MSA” (Cass, Douglas, Sarpy, and Washington Counties) is 629,294 people. The “Lincoln, NE MSA” (Lancaster County) has 250,291. These two MSAs have 879,585 people accounting for 51.4% of the state population.

The Nebraska portion of the “Sioux City, IA—NE MSA” (Dakota County, NE) has 20,253 people. When combined with the other two MSAs in Nebraska, there is a total of 899,838 people accounting for 52.6% of the 1,711,263.

Micropolitan Statistical Areas 10,000 to 49,999

The COUNTY is in CAPS; the Core Based Statistical Area Population of 10,000 to 49,999 is noted as the “city” within the county listed.

- Region I has SCOTTS BLUFF (36,951) with the Scottsbluff / Gering Area (23,129) consisting of the cities of Scottsbluff (14,732), Gering (7,751), and Terrytown (646).

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- Region II has LINCOLN (34,632) with the City of North Platte (23,878) and DAWSON (24,365) with the City of Lexington (10,011)
- Region III has HALL (53,534) with the City of Grand Island (42,940); BUFFALO (42,259) with the City of Kearney (27,431); and ADAMS (31,151) with the City of Hastings (24,064).
- Region IV has MADISON (35,226) with the City of Norfolk (23,516); PLATTE (31,662) with the City of Columbus (20,971);
- Region V has GAGE (22,993) with the City of Beatrice (12,496)
- Region VI has DODGE (36,160) with the City of Fremont (25,174)

Rural and Frontier areas

On the other end of things would be the Frontier area concept. According to Rural Policy Research Institute (University of Missouri, Columbia, MO) the term "Frontier Area" is used to describe an area with extremely low population density. Frontier Areas are isolated rural areas characterized by considerable distances from central places, poor access to market areas, and people's relative isolation from each other in large geographic areas.

The National Rural Institute on Alcohol and Drug Abuse uses the following definitions:

- Rural areas contain 50 or fewer people per square mile
- Frontier areas contain 6 or fewer people per square mile.

Overall, Nebraska has 22.3 Persons Per Square Mile.

Applying these standards to Nebraska's "Population Density By County" shows:

- 52 – Rural counties (604,757 population; 35% total population / areas containing 50 or fewer people per square mile)
- 33 – Frontier Counties (93,711 population; 5% total population / areas contain 6 or fewer people per square mile).
- 8 – remaining Nebraska Counties (1,012,795 population, 59% total population / with more than 50 people per square mile. The Nebraska Counties with more than 50 people per square mile were Adams, Hall (Region 3), Madison, Dakota (Region 4), Lancaster (Region 5) and Dodge, Sarpy, Douglas (Region 6).

Source: Fact Sheet #1 "Definitions of Rural"

National Rural Institute on Alcohol and Drug Abuse; University of Wisconsin-Stout;
140 Vocational Rehabilitation Building; P.O. Box 0790; Menomonie, WI 54751-0790

Nebraska has **33 Frontier Area counties**. This includes 11 counties with less than 1,000 people [Keya Paha (983), Wheeler (886), Banner (819), Hooker (783), Logan (774), Grant (747), Thomas (729), Loup (712), Blaine (583), McPherson (533), And Arthur (444)].

Estimate of the Incidence and Prevalence in the State of Serious Mental Illness Among Adults

URS Table 1: Number of persons with serious mental illness, age18 and older, by State, 2002				
	Resident Population	Resident Population	Lower Limit	Upper Limit
	Population 2002	with SMI (5.4%)	of estimate (3.7%)	of estimate (7.1%)

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Nebraska	1,289,787	69,648	47,722	91,575
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Source: Deborah Baldwin <DBaldwin@samhsa.gov> 7/20/2004
 U.S. Department of Health & Human Services
 Center for Mental Health Services (CMHS)

Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Information on prevalence estimates for SMI and SED.
 U.S. Department of Health & Human Services, Center for Mental Health Services (CMHS)

Number SPMI Served by Region for State FY2002 by Estimated Number of SPMI by Region								
	REGIONS							
	1	2	3	4	5	6	Unknown	Total
Value = Percent Treated FY2002 (of SPMI)	25.7%	24.0%	29.4%	16.6%	25.6%	23.7%		24.3%
Value = Percent Treated FY2002 (of the 7,556)	5.60%	5.92%	15.70%	8.62%	25.41%	37.92%	0.85%	100.00%
Numerator = SPMI Served by Region in FY2002	423	447	1186	651	1920	2865	64	7,556
Adults in NE who have a severe and persistent mental illness (SPMI)	1,645	1,862	4,034	3,910	7,510	12,072	N/A	31,033
Adults in NE who have a serious mental illness (SMI)	3,289	3,724	8,069	7,820	15,020	24,144	N/A	62,066

Nebraska Population by Mental Health Region (Census 2000)							
	1	2	3	4	5	6	State Total
Population age 18 Years & Older / Region Total	66,834	75,661	163,933	158,889	305,167	490,537	1,261,021
Total Region Population	90,410	102,311	223,143	216,388	413,557	665,454	1,711,263
Region % =	5.30%	6.00%	13.00%	12.60%	24.20%	38.90%	100.00%

Data source: HHS Office of Mental Health, Substance Abuse, and Addiction Services.

- Adults in Nebraska have a serious mental illness (SMI) (5.4% of adults)
 *source: Federal Register / Vol. 64, No. 121 / Thursday, June 24, 1999; page 33896

Note: Civilian Population with SMI = 67,701

Civilian population excludes military personnel residing in the geographic area. Rationale is that these personnel are served by the Military or health insurance coverage provided by the military. Source: U.S. Department of Health & Human Services, Center for Mental Health Services January 2003

- AGE: · 18 years & older is 1,261,021; Under 18 years is 450,242; and TOTAL Nebraska Population is 1,711,263. Source: Nebraska Databook, (Last Updated on 5/21/01). Based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001. <<http://info.neded.org/stathand/bsect8.htm>>

Federal Serious Mental Illness (SMI) Criteria - Pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illness SMI are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. (3) That has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425.

For the purposes of the Nebraska Mental Health Block Grant reporting the number of persons served who meet this SMI criteria, the following methods were used to operationalize this definition:

Step 1: a diagnosable mental, behavioral, or emotional disorder

Diagnosis # 295 - 298.9 [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) © 2000 American Psychiatric Association. Schizophrenia (295), Mood Disorders including Bipolar and Major Depression (296), Delusional Disorder (297.1), Shared Psychotic Disorder (297.3), Brief Psychotic Disorder (298.8), and Psychotic Disorder NOS (298.9) ["Not Otherwise Specified"]. ... and ...

Step 2: resulted in functional impairment – **The functional impairment component of the SMI designation is addressed by:**

- a. SSI/SSDI eligible (include eligible receiving pay, eligible not receiving pay, potential eligible) or
- b. Served in one of the NBHS funded Community Mental Health Rehabilitation Based Services (Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services) or
- c. Have an Axis V – Global Assessment of Functioning (GAF) Scale score of less than 60.

STATE REGIONAL CENTER DATA (State Psychiatric Hospitals)
Lincoln Regional Center, Norfolk Regional Center, Hastings Regional Center

Adults, Age 18 or older, Inpatient (Actual)

Prepared by Paula Hartig, July 26, 2004; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

Number of Admissions to a State Regional Center				
FY2001	FY2002	FY2003	FY2004	
1,086	1,097	1,115	1,148	Number of admissions
699	693	667	730	Number of admissions with SMI
453	430	551	619	Number of admissions with a substance abuse diagnosis

Number of Discharges from a State Regional Center				
FY2001	FY2002	FY2003	FY2004	
714	614	660	722	Total discharges with SMI
1,094	1,087	1,165	1,146	Total discharges

Number of Patients-In-Residence in State Regional Center on the Last Day of the Fiscal Year				
FY2001	FY2002	FY2003	FY2004	
285	322	295	280	Number of patients-in-residence with SMI
478	469	432	431	number of patients-in-residence on the last day of the FY

Average/median length of stay (in days) for persons with a SMI discharged from a State Regional Center				
FY2001	FY2002	FY2003	FY2004	
153.7 days	185.9 days	159.0 days	166.3 days	Average length of stay
55.0 days	66.0 days	62.0 days	59.0 days	Median length of stay

Percent of Discharges from State Regional Center inpatient units who were Readmitted within 30 days of discharge**				
FY2001	FY2002	FY2003	FY2004	
4.5%	4.8%	6.1%	4.8%	Value
46	49	64	46*	Readmitted within 30 days
1,018	1,024	1,048	952	Number of discharges

Percent of Discharges from State Regional Center inpatient units who were Readmitted within 180 days of discharge**				
FY2001	FY2002	FY2003	FY2004	
18.2%	14.6%	18.1%	Not Av.	Value
185	149	190	Not Av.	Readmitted within 180 days
1,018	1,024	1,048	952	Number of discharges

* estimated, based on 11 months of readmission data

** Does not include transfers between regional centers or persons discharged for short-term treatment in a general hospital who are expected to return.

**Regional Center Unduplicated Persons Served
Inpatient Services FY2001 - FY2004 Age 18+**

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	FY2001		FY2002		FY2003		FY2004	
	N	%	N	%	N	%	N	%
TOTAL ADULTS SERVED	1,260	---	1,375	---	1,353	---	1,223	---
Age:								
18-19 years	69	5.5%	62	4.5%	65	4.8%	55	4.5%
20-24 years	126	10.0%	164	11.9%	172	12.7%	159	13.0%
25-34 years	322	25.6%	305	22.2%	342	25.3%	313	25.6%
35-44 years	355	28.2%	411	29.9%	371	27.4%	342	28.0%
45-54 years	226	17.9%	275	20.0%	267	19.7%	224	18.3%
55-64 years	111	8.8%	111	8.1%	96	7.1%	97	7.9%
65-74 years	30	2.4%	32	2.3%	27	2.0%	28	2.3%
75+ years	21	1.7%	15	1.1%	13	1.0%	5	0.4%
Gender:								
Male	939	68.7%	950	69.1%	897	66.3%	848	69.3%
Female	427	31.3%	425	30.9%	456	33.7%	375	30.7%
Employment Status:								
Student	49	3.9%	24	1.7%	39	2.9%	22	1.8%
Unemployed	855	67.9%	1,004	73.0%	996	73.6%	938	76.7%
Disabled	178	14.1%	182	13.2%	173	12.8%	167	13.6%
Employed - Full-Time	120	9.5%	110	8.0%	96	7.1%	64	5.2%
Employed - Part-Time	24	1.9%	24	1.7%	22	1.6%	14	1.1%
Homemaker	2	0.2%	4	0.3%	2	0.1%	2	0.2%
Retired	29	2.3%	22	1.6%	23	1.7%	12	1.0%
Other	3	0.2%	5	0.4%	2	0.1%	4	0.3%
Race:								
White	1,063	84.4%	1,174	85.4%	1,124	83.1%	1,023	83.6%
Black/African American	129	10.2%	141	10.3%	150	11.1%	151	12.3%
American Indian	34	2.7%	30	2.2%	34	2.5%	18	1.5%
Asian/Pacific Islander	7	0.6%	8	0.6%	11	0.8%	10	0.8%
Bi-Racial	10	0.8%	4	0.3%	13	1.0%	9	0.7%
Other	16	1.3%	11	0.8%	15	1.1%	8	0.7%
Not Reported	1	0.1%	7	0.5%	6	0.4%	4	0.3%
Hispanic Origin:								
Yes	26	2.1%	40	2.9%	49	3.6%	40	3.3%
No	1,234	97.9%	1,335	97.1%	1,304	96.4%	1,183	96.7%
Legal Status at Admission:								
Voluntary	213	16.9%	143	10.4%	122	9.0%	112	9.2%
Court Order	130	10.3%	138	10.0%	142	10.5%	105	8.6%
Mental Health Board Commitment	830	65.9%	1,045	76.0%	1,061	78.4%	983	80.4%
EPC	39	3.1%	43	3.1%	26	1.9%	6	0.5%
Other	48	3.8%	6	0.4%	2	0.1%	17	1.4%
Diagnosis (Axis I Primary):								
Schizophrenia	297	23.6%	437	31.8%	430	31.8%	422	34.5%
Substance Abuse (alcohol/drugs)	165	13.1%	185	13.5%	174	12.9%	151	12.3%
Bipolar Disorder	140	11.1%	165	12.0%	189	14.0%	145	11.9%
Major Depressive Disorder	105	8.3%	124	9.0%	106	7.8%	94	7.7%
Other Psychoses	175	13.9%	57	4.1%	55	4.1%	62	5.1%
Sexual Disorder	90	7.1%	126	9.2%	108	8.0%	92	7.5%

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Other	288	22.9%	281	20.4%	291	21.5%	257	21.0%
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**Demographic Overview of Mental Health Persons Served Nebraska Mental Health System
Community Based Programs - Adults Served**

Magellan Behavioral Health / Unduplicated Persons Served / Age 18+ FY2001, FY2002 and FY2003						
	FY2001		FY2002		FY2003	
	N	%	N	%		
TOTAL ADULTS SERVED	30,900	100%	33,821	100%	31,587	100%
By Age:	30,900	100%	33,821	100%	31,587	100%
18-20 years	3,045	9.9%	3,051	9.0%	2,238	7.1%
21-64 years	27,062	87.6%	29,966	88.6%	28,645	90.7%
65-74 years	493	1.6%	516	1.5%	430	1.4%
75 + years	300	1.0%	288	0.9%	274	0.9%
By Gender:	30,900	100.0%	33,821	100.0%	31,587	100.0%
Male	18,451	59.7%	19,982	59.1%	18,566	58.8%
Female	12,395	40.1%	13,796	40.8%	13,005	41.2%
Not reported	54	0.2%	43	0.1%	16	0.1%
Employment Status:	30,900	100.0%	33,821	100.0%	31,587	100.0%
Student	473	1.5%	367	1.1%	52	0.2%
Unemployed	6,171	20.0%	6,676	19.7%	6,784	21.5%
Disabled	1,359	4.4%	1,133	3.4%	663	2.1%
Employed - Full-Time	10,876	35.2%	10,818	32.0%	10,097	32.0%
Employed - Part-Time	3,865	12.5%	4,132	12.2%	4,169	13.2%
Homemaker	208	0.7%	151	0.5%	55	0.2%
Retired	135	0.4%	80	0.2%	45	0.1%
Other	6,985	22.6%	9,750	28.8%	9,434	29.9%
Unknown/Not reported	828	2.7%	714	2.1%	288	0.9%
						0.0%
Race:	30,900	100.0%	33,821	100.0%	31,587	100.0%
White	24,835	80.4%	27,378	81.0%	25,763	81.6%
Black/African American	2,587	8.4%	2,867	8.5%	2,459	7.8%
American Indian	1,025	3.3%	1,072	3.2%	1,048	3.3%
Asian/Pacific Islander	163	0.5%	167	0.5%	191	0.6%
Alaskan Native	27	0.1%	35	0.1%	35	0.1%
Other	1,943	6.3%	1,950	5.8%	1,719	5.4%
Unknown/Not reported	320	1.0%	352	1.0%	372	1.2%
Hispanic Origin:	30,900	100.0%	33,821	100.0%	31,587	100.0%
Yes	28,070	90.8%	30,838	91.2%	1,788	5.7%
No	1,954	6.3%	1,997	5.9%	28,874	91.4%
Unknown/Not Reported	876	2.8%	986	2.9%	925	2.9%
Legal Status at Admission:	30,900	100.0%	33,821	100.0%	31,587	100.0%

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Voluntary	13,474	43.6%	15,065	44.5%	15,723	49.8%
Court Order	2,713	8.8%	2,782	8.2%	2,447	7.7%
Mental Health Board Commitment	1,001	3.2%	1,163	3.4%	1,640	5.2%
EPC	1,691	5.5%	2,552	7.6%	1,955	6.2%
Other	8,353	27.0%	8,782	26.0%	8,922	28.2%
Not reported	3,668	11.9%	3,477	10.3%	900	2.8%

Demographic Overview of Mental Health Persons Served Nebraska Mental Health System
Community Based Programs - Adults Served
Magellan Behavioral Health / Unduplicated Persons Served / Age 18+
FY2001, FY2002 and FY2003

(ii) Goals, Targets and Action Plans

Criterion 2: Mental Health System Data Epidemiology

FY 2005 Nebraska MENTAL HEALTH PLAN

PERFORMANCE INDICATORS

GOAL: To maintain if not increase the number of people receiving Mental Health Services.

OBJECTIVE: To maintain if not increase the number of persons age 18 or older (unduplicated count) in FY2005 (increase program capacity under Behavioral Health Reform).

POPULATION: Adults receiving mental health services within the Nebraska Behavioral Health System (NBHS)

Magellan Behavioral Health Unduplicated Persons Served / Age 18+				
Performance Indicator	FY2003 Actual	FY2004 Projected	FY2004 Actual	FY2005 Target
M H Services only	17,432	17,000		18,000

Data source: from Nebraska Division of Behavioral Health Services

Federal Uniform Reporting System / NE Implementation Report 2003.

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

- Data limited to community mental health as reported to Magellan Behavioral Health for the Office of Mental Health, Substance Abuse and Addiction Services.

	Female	Male	Not Available	Total
0-3 Years	92	133	20	245
4-12 years	396	656	0	1,052
13-17 years	495	641	0	1,136
18-20 years	433	491	0	924

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21-64 years	8,259	7,635	5	15,899
65-74 years	214	131	1	346
75+ years	142	96	0	238
Not Available	12	13	0	25
Total	10,043	9,796	26	19,865

Criterion 4: Targeted Services to Rural and Homeless Populations

- Describes State's outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals in rural areas

Criterion 4: Describes State's outreach to and services for individuals who are HOMELESS

(i) Current Activities

NEBRASKA HOMELESS ASSISTANCE PROGRAM AWARDS

The Nebraska Department of Health and Human Services (HHS) administers the Nebraska Homeless Assistance Program (NHAP). The purpose of the NHAP is to provide an overall "Continuum of Care" approach to address the needs of people who are homeless and near homeless in Nebraska, by:

- Assisting in the alleviation of homelessness,
- Providing temporary and/or permanent shelters for persons who are homeless,
- Addressing the needs of the migrant farm workers,
- Encouraging the development of projects that link housing assistance programs with efforts to promote self-sufficiency.

NHAP is a grant program consisting of the Nebraska Homeless Assistance Trust Fund (HSATF) and the Department of Housing and Urban Development (HUD) Emergency Shelter Grant (ESG). There are \$2.55 in state HSATF funds matching each federal ESG dollar. The intent of the HHS is to award these funds through a regional and programmatic activity specific allocation process. Organizations are encouraged to seek other sources of funding and collaborate and coordinate programs and services with other organizations to optimize the use of NHAP funds.

In FY2004 (ending June 30, 2004) 71,239 people across the state were assisted by the 70 programs funded by the Nebraska Homeless Assistance program. This is an unduplicated count. These numbers include adults with serious mental illness as well as others who are homeless or near homeless.

28,105	unduplicated homeless individuals
43,134	unduplicated individuals who were near homeless
71,239	total unduplicated individuals

The regions used by the Continuums of Care are defined by the NHAP.

2004 Total Award	
Region 1 Total Award	\$183,891
Region 2 Total Award	\$301,553

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Region 3 Total Award	\$277,209
Region 4 Total Award	\$458,977
Region 5 Total Award	\$382,701
Region 6 Total Award	\$307,863
Region 7 Total Award	\$574,105
NAF – Statewide: discretionary fund	\$11,000
Total NHAP for Nebraska	\$2,497,299
Lincoln & Omaha ESGP	\$297,940
Total State & Federal Homeless Awards	\$2,795,239

For more information on the Nebraska Homeless Assistance Program visit the HHSS web site at <http://www.lhs.state.ne.us/fia/nhap/nhapindex.htm> or contact Jean Chicoine, NHAP Specialist [(402) 471-9644 / jean.chicoine@hhss.state.ne.us].

Projects for Assistance In Transition from Homelessness (PATH)

The Nebraska Department of Health and Human Services contracts with the Regional Behavioral Health Authorities (LB1083, Section 7-9) for delivery of community mental health services including contracts for the implementation of PATH Formula Grant activities.

- Service Areas: Based on the evidence of need, the two primary geographic areas within Nebraska receiving most of the PATH funds are Lincoln (in Region 5) and Omaha (in Region 6). This is based on the fact that Lincoln and Omaha have the greatest numbers of homeless individuals in Nebraska. PATH funds will also be allocated in two other locations in the state: Scottsbluff (in Region 1) and Grand Island (in Region 3).
- Services to be supported by PATH Funds: The PATH programs will provide outreach, screening and diagnostic treatment services, case management, referral, some temporary housing assistance, and other appropriate services to individuals who are suffering from serious mental illness or are suffering from serious mental illness and from substance abuse, and are homeless or at imminent risk of becoming homeless.
- Number of Persons to be served: The estimated number of persons that will be served in FY04 statewide is 964.

Organizations to Receive Funds and Amounts Allocated (FY2004):

Region 1 – Western Nebraska Scottsbluff	Cirrus House: (Private non-profit entity)	\$11,333	4%
Region 3 – Central Nebraska Grand Island	Central Nebraska Goodwill Industries, Inc. (Private non-profit)	\$11,333	4%
Region 5 – Southeast Nebraska Lincoln and Lancaster County	Community Mental Health Center/Lancaster County (Public, County Governmental Entity)	\$32,500	11%
	CenterPointe, Inc. (Private, non-profit)	\$32,500	11%
Region 6 – Eastern Nebraska Omaha and Douglas County	Community Alliance (Private, non-profit)	\$147,213	51%
	Salvation Army (Private, non-profit)	\$53,121	18%
TOTAL		\$288,000	100%

Criterion 4: Describes how community-based services will be provided to individuals in RURAL AREAS

(i) Current Activities

Under Criterion 2, using 2000 Census data, 899,838 (52.6%) of the 1,711,263 residents in Nebraska live in six (6) counties classified as Metropolitan Areas. That means there are 811,425 (47.4%) residents who live in Micropolitan (10,000 to 49,999 residents), Rural or Frontier (less than 7 persons/sq.mi.) areas.

Most of this Federal Mental Health Block Grant application has been addressing how community-based services are provided. From the Nebraska Division of Behavioral Health Services point of view, the same general approach is used within each geographic area.

Regional Behavioral Health Authorities (RBHA) exercise “local control” in partnership with the State of Nebraska. This local control is very important due to the challenges of providing services in each of these four types of geographic areas (Metropolitan, Micropolitan, Rural or Frontier). There must be flexibility in delivery/provision of “accessible” mental health services in each of these four types of areas. In addition to the services offered via the RBHAs, there is one specialized rural program Nebraska funds through the Division of Behavioral Health Services. It is the Rural Mental Health Hotline and Voucher Program.

Rural Mental Health Hotline and Voucher Program

This program provides hotline and crisis counseling services to the rural residents of Nebraska. The demand for these services continues to increase as those who derive their livelihood from the rural economy continue to face the stress of low prices, increased costs, and drought.

Rural residents calling the toll-free Nebraska Farm Hotline (1-800-464-0258) who present to be in need of professional mental health treatment are informed of the “Voucher Program”. The “Voucher Program” is designed to make cost-free, confidential mental health counseling available to persons affected by the current rural farm crisis. The program is not limited to farmers. Any rural person who is negatively impacted by the rural crisis may apply. This includes farm family members, those employed in agriculture-related businesses and small town businesses dependent on the agricultural economy, and other rural residents.

Upon request from the caller, Farm Hotline staff mails a voucher with a list of mental health providers in their geographic area and contact information. Each voucher pays for one outpatient session. The caller has 30 days to redeem the voucher by receiving counseling from an approved provider of their choice on the list. If more than one session is needed, up to 5 additional vouchers for therapist prescribed sessions can be obtained by calling the Hotline. Additional sessions, if needed, are often provided free by the provider as the need in the rural/frontier areas is critical. Mental health providers are reimbursed at the rate of \$60.00 for each 50-60 minute session provided.

Currently, 189 licensed (a requirement) mental health providers in every part of the state have signed on to provide services under the Voucher Program. As of June 30, 2004, 68 providers were currently active. A large number of providers have strong farm backgrounds and an understanding of rural culture.

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The voucher program is managed on a per month allotment so the program will have funds for the entire year. For FY 2004, the funding to the “Rural Mental Health Crisis Counseling Program” is \$100,000.

(ii) Goals, Targets and Action Plans

GOAL: With the Rural Mental Health Program, provide services to the rural residents of Nebraska impacted by the prolonged decline of the farm/rural economy in Nebraska.

OBJECTIVE: In FY2004, provide 2,500 counseling sessions to 800 people (individuals or families) under the crisis counseling vouchers program.

POPULATION: Residents of Nebraska's rural and frontier areas including farmers, ranchers, spouses, children, and others who are directly affected by the continued economic crisis.

Value: average number of sessions per individual/family

Numerator: unduplicated count / people served (individual or family)

Denominator: total number of counseling sessions

Performance Indicator:	FY2003 Actual	FY2004 Projected	FY2004 Actual	FY2005 Target
Value:	2.4	2.5	3.14	3.0
Numerator	845	800	901	850
Denominator	2025	2000	2834	2550

Discussion: In FY 2004, the entire \$100,000 was used for the Voucher Program as the demand for vouchers increased significantly in rural Nebraska due to drought, increased production costs, and low farm prices.

Data source: from Nebraska Division of Behavioral Health Services

Criterion 5: Management Systems

Criterion 5: Management Systems

- Describes financial resources, staffing and training for mental health services providers necessary for the plan;
- Provides for training of providers of emergency health services regarding mental health; and
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

(i) Current Activities

(ii) Goals, Targets and Action Plans

Criterion 5 - Describes financial resources, staffing and training for mental health services providers necessary for the plan

- **Describes financial resources**
- **Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.**

See PART B. "Fiscal Planning Assumptions" for details on how the state intends to expend the grant under Section 1911.

- Criterion 5 - staffing

On July 1, 2004, the functions of the Office of Mental Health, Substance Abuse and Addiction Services were added to the new Division of Behavioral Health Services. At this time, there are 12 professional staff, plus Prevention Professional staff, support FTE and student interns (part-time). All staff have a variety of job duties. Ron Sorensen is the Administrator for the Office of Mental Health, Substance Abuse and Addiction Services. Barb Thomas is the Assistant Director. The Field Representative are Sue Adams (Regions 1 & 2), Tim Christensen (Region 3), Kathi Samuelson (Region 4), Linda Wittmuss (Region 5), and Dennis Snook (Region 6). Phyllis McCaul and Dan Powers are the Consumer Liaisons. Jim Harvey assignments include addressing the Mental Health Block Grant requirements. Bob Bussard assignments include addressing the Substance Abuse Block Grant. Tim Christensen and Gordon Tush work on the Compulsive Gambling program. In addition to the 12 staff noted above, Lisa Franz in HHS-Services / Developmental Disabilities has duties that include working with the Regional Centers.

- Criterion 5 - training

NAMI- NE is to develop an infrastructure for a mental health education, support and advocacy presence in Nebraska and to provide specific family education , support, information, advocacy and related functions for consumers of mental health services and their families in Nebraska. One of the consumer liaisons serves as a trainer in NAMI-NE's "Journey of Hope" training's.

Magellan Provider Training – Magellan Behavioral Health continues to provide training with all contract providers on managed care issues with the renewal of the ASO contractor effective January 1, 2000.

The Department will continue to sponsor trainings for consumers/providers covering the recovery concept. For example, the Department continues to support the Aurora, Nebraska conference designed to provide training to consumers. There are 130 consumers expected to participate in each year's conference. Most of these consumers are users of the Department funded psychiatric rehabilitation programs. The Consumer Conference is usually held in September.

Suicide Prevention Curricula being delivered via a train the trainers model. This model develops and maintains local expertise in suicide prevention. The target population for this pilot was adults in Southeast Nebraska with emphasis on reaching those at highest risk for suicide. For more information, see ADULT GOAL #3: SUICIDE PREVENTION INITIATIVE.

Criterion 5 - Provides for training of providers of emergency health services regarding mental health

NOTE: this material applies to both Adults and Youth.

Training for the Mental Health Boards

The Department of Health and Human Services (HHS) is responsible for training of Mental Health Boards under LB1083. There are approximately twenty-eight mental health boards across the state.

The 2004 training will be provided by the Division of Behavioral Health Services. The training will consist of protocols/procedures for both outpatient and inpatient commitment, procedures for forced medication, judicial immunity for Mental Health Board members, new forms to be used in the commitment process, definitions of Mental Illness and Substance Dependency, authority for R&L to access patient records upon delivery of a subpoena in connection with a licensing or licensure investigation by the department, change in language clarifying the HHS may release patient's name and other identifying characteristics when that person is absent without authorization and such disclosure would aid in the apprehension and to warn the public of danger.

The Nebraska training events and dates for 2004 will be held in Gering on October 20, Kearney on November 3, and in Lincoln on November 17, 2004,.

Participants invited to the Mental Health Board training each year are involved some aspect of the Emergency Health Services as defined under the "Nebraska Mental Health Commitment Act". The participants invited annually include Regional Center Emergency Coordinators, Crisis Center Directors, Regional Program Administrators, members of the Boards of Mental Health, County Attorney's, Public Defender's, Clerks of the District Courts, members of the State Behavioral Health Council (LB 1083 Sec. 13), the State Advisory Committee on Mental Health Services (LB 1083 Sec. 14), the State Advisory Committee on Substance Abuse Services (LB 1083 Sec. 15), Regional Center personnel as well as HHS staff.

Under Section 36 (1) of LB1083, HHS shall provide appropriate training to members and alternates of each Mental Health Board. HHS shall consult with consumer and family advocacy groups in the development and presentation of such training. The section says no person shall remain on a Mental Health Board or be eligible for appointment or reappointment as a member or alternate of such board unless he or she has attended and satisfactorily completed such training pursuant to rules and regulations adopted and promulgated by HHS.

The Mental Health Commitment Boards play a key role in Nebraska. Sections 21 to 82, 88-89, and 126 of LB 1083 amended and updated the "Nebraska Mental Health Commitment Act". One

of the aspects of the Nebraska Mental Health Commitment Act includes the proceedings of the Mental Health Boards.

One of the starting points for the commitment cycle is with an emergency protective custody (EPC). If a Law Enforcement Officer has probable cause to believe that a person is mentally ill and dangerous and the harm is likely to occur before a Mental Health Board proceedings can be arranged, the Officer may take such person into emergency protective custody (EPC). The person shall be admitted to the nearest appropriate and available medical facility and shall not be placed in a jail. The medical facility shall complete an evaluation by a mental health professional of the person no later than thirty-six hours after admission. The person shall be released from the EPC after completion of such evaluation unless the mental health professional determines, in his or her clinical opinion, that such person is mentally ill and dangerous.

The County Attorney receives a copy of the evaluation. If the County Attorney concurs that such person is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the person's liberty than inpatient or outpatient treatment ordered by a Mental Health Board is available, he or she shall file a petition. The petition is for a hearing by the Mental Health Board. The hearing needs to be held within seven calendar days after the person has been taken into emergency protective custody.

The hearing is held by the Mental Health Board to determine whether there is clear and convincing proof evidence that the subject is mentally ill and dangerous as alleged in the petition filed by the County Attorney. Treatment may be ordered by the Mental Health Board. Such services shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the person. If the Mental Health Board finds the subject to be mentally ill and dangerous and commits the subject to the custody of the Department of Health and Human Services to receive inpatient treatment, the Department shall secure placement of the subject in an appropriate inpatient treatment facility to receive such treatment.

Disaster Mental Health Training - HHS has established an intergovernmental agreement with the University of Nebraska Public Policy Center to develop an All-Hazards Disaster Behavioral Health Response and Recovery Plan for the State of Nebraska. The goal is to develop human infrastructure in Nebraska to effectively mitigate or respond to the psycho-social consequences of terrorism and disaster. This includes fostering links between mental health/substance abuse resources and public health systems, healthcare networks, emergency management, and first responder groups.

The University of Nebraska Public Policy Center is also working with the University of Nebraska Medical Center to create a curriculum in "Psychological First Aid". This will help prepare school personnel, healthcare professionals, faith leaders, and other natural helpers to augment the professional behavioral health response to terrorism and disaster.

Stakeholders from across the State and across disciplines are involved in this project. Community groups, faith groups, public and private entities and key responders like the American Red Cross, Nebraska's Critical Incident Stress Management Team, and Nebraska State Agencies are all collaborating with the Public Policy Center in this endeavor. For more information see <<http://www.disastermh.nebraska.edu/>>

The Nebraska Disaster Behavioral Health Conference was held on July 8-9, 2004 at the Doubletree Hotel Downtown in Omaha, NE. This two-day workshop focused on practical skill development for clinicians and community responders. The Target Audience for this conference included Psychiatrists, Psychologists, Social Workers, Mental Health Care Providers, Public Health Officials, Nurses, Clergy, Substance Abuse Workers, Emergency Managers and First Responders. 197 attended the conference.

Conference Objectives / For the "Clinical Track":

- Describe core principles, stumbling blocks, and strategies of crisis and emergency risk communication:
- Learn specific interventions to use in disaster and recovery.
- Educate about current disaster research and it's implications for treatment.
- Understand the Public Health approach to mental health effects of terrorism.

Conference Objectives / For the "Community Responder Track":

- Describe physiological, emotional and spiritual dimensions of trauma.
- Define compassion fatigue and recognize who is most vulnerable and review prevention strategies.
- Explore emotional first aid that assists individuals, families and communities.
- Learn interventions that strengthen individuals and communities.

Critical Incident Stress Management

Critical Incident Stress Management (CISM) Program is a key resource for Nebraska's capacity to provide mental health disaster response services. The CISM program is authorized by the "Critical Incident Stress Management Act (Neb. Rev. Stat. §§ 71-7101 to 71-7113)". There are five State of Nebraska Departments sponsoring this program:

- Department of Health and Human Services Regulation and Licensure / Emergency Medical Services (EMS) Program
- Department of Health and Human Services / Office of Mental Health, Substance Abuse and Addiction Services
- Nebraska State Patrol
- State Fire Marshal
- Nebraska Emergency Management Agency

Please note that Office of Mental Health, Substance Abuse and Addiction Services staff serve on the CISM Interagency Management Committee.

The Nebraska Critical Incident Stress Management Program trains volunteers to provide crisis support to reduce the harmful effects of critical incident stress for; law enforcement officers; firefighters; emergency medical services, corrections, hospitals, and emergency management personnel; and dispatchers. There is an annual conference (first weekend after Memorial Day) where a lot of training on mental health disaster related topics occurs.

The core functions of the Nebraska Statewide Critical Incident Stress Management Program are:

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- Recruitment and retention of volunteers (training, continuing education);
- Intervention services (defusings, debriefings, referral);
- Prevention (education, consult agencies).

For more information on this program see <<http://www.hhs.state.ne.us/ems/emscism.htm>>.

(ii) Goals, Targets and Action Plans

Criterion 5: Management Systems

GOAL: At least maintain the Per Capita State Expenditures for Community Mental Health Services

FY 2004 Nebraska MENTAL HEALTH PLAN PERFORMANCE INDICATORS	
Population: SMI Adults	
Criterion 5: Management Systems	

GOAL: At least maintain the Per Capita State Expenditures for Community Mental Health Services

OBJECTIVE: By June 30, 2004, the per capita state expenditures for community mental health services will be maintained over \$15.00

POPULATION: Total population

Per Capita State Expenditures for Community Mental Health Services

Numerator = FY2001 and FY2002 is “actual” Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)

Numerator Data source: Office of Mental Health, Substance Abuse and Addiction Services

Denominator = Total State population

Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001 <<http://info.neded.org/stathand/bsect8.htm>>

Performance Indicator:	FY 2003 Actual	FY2004 Objective	FY2004 Actual	FY2005 Target
Value:	\$16.97	\$17.46		\$18.24
Numerator	\$29,036,852	\$29,874,816		\$31,207,611
Denominator	1,711,263	1,711,263		1,711,263

Federal Requirements:

CMHS Core Performance Indicators

APPLIES TO BOTH CHILDREN AND ADULTS

1. There are four Core Performance Indicators required by the OMB PART. States are expected to incorporate these core indicators along with the State-specific indicators in the FY 2005 Plan. In future years, requirements for reporting on the remaining Core Performance Indicators will be phased in and updated as needed.

2. The location of the Core Performance Indicators within the five criteria.

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Working from Table 4 - CMHS Core Performance Indicator Chart, Nebraska does not have the capacity to report the following items at this time:

INDICATORS EXPECTED IN 2005 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST				
3. Evidence-Based Practices*	Number of Evidence-based Practices Provided by State	Criteria 1 and 3	Developmental Tables 16 and 17	Yes
	Number of Persons Receiving Evidence-based Practice Services	Criteria 1 and 3	Developmental Tables 16 and 17	Yes
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
5. Increase in Employment or Return to School	Profile of Adult Clients by Employment Status	Criterion 1	Basic Table 4	No
	Increased school attendance	Criteria 1 and 3	Developmental Table 19C	No
6. Decreased Criminal Justice Involvement	Profile of Client Involvement in Criminal and Juvenile Justice Systems	Criteria 1 and 3	Developmental Table 19A and 19B	No

Federal Requirements / CMHS Core Performance Indicators

PPG Core Performance Indicators*		Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS EXPECTED IN 2005 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST				
1. Increased Access to Services	Number of Persons Served	Criteria 2 and 3	Basic Tables 2A and 2B	Yes

NOTE: The performance measure does not include by Age, Gender, and Race/Ethnicity, per the July 7, 2004 conference call with Deborah Baldwin on Mental Health Block Grant Plans . Applications for FY2005, the performance measure is limited to just the number of persons served. The Age, Gender, and Race/Ethnicity is not included.

NE URS 2003

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

	Female	Male	Not Available	Total
0-3 Years	92	133	20	245
4-12 years	396	656	0	1,052
13-17 years	495	641	0	1,136
18-20 years	433	491	0	924

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21-64 years	8,259	7,635	5	15,899
65-74 years	214	131	1	346
75+ years	142	96	0	238
Not Available	12	13	0	25
Total	10,043	9,796	26	19,865

GOAL 1. Increased Access to Services

POPULATION: The persons served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services as reported within the Magellan Behavioral Health Information System

Value: Total Persons Served (both children and adults) as reported on URS Table 2a & 2B

Performance Indicator:	FY2003 Actual	FY2004 Projected	FY2004 Actual	FY2005 Target
Value:	19,865	19,865		19,000

Discussion: Per the July 7, 2004 conference call with Deborah Baldwin on block Grant Plans . Applications for FY2005, the performance measure is limited to just the number of persons served. The Age, Gender, and Race/Ethnicity is not included.

Data source: from Nebraska Division of Behavioral Health Services
NE Uniform Reporting System 2003 / Table 2A. Profile of Persons Served

Federal Requirements
CMHS Core Performance Indicators

PPG Core Performance Indicators*	Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS EXPECTED IN 2005 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST			
<u>2. Reduced Utilization of Psychiatric Inpatient Beds</u>	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days	Criteria 1 and 3	Developmental Table 20A Yes

GOAL 2. Reduced Utilization of Psychiatric Inpatient Beds

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POPULATION: Adults, Age 18 or older, Inpatient at the State Psychiatric Hospitals
Lincoln Regional Center, Norfolk Regional Center, Hastings Regional Center
Does not include transfers between regional centers or persons discharged for short-term treatment in a general hospital who are expected to return.

OBJECTIVE: By June 30, 2005, the percentage of re-admissions to the Regional Centers decreased by 5%.

Value: Percentage of persons readmitted to Regional Centers within 30 days of discharge

Numerator: Readmitted within 30 days

Denominator: Number of discharges

Numerator and Denominator Data Source: Regional Centers / AIMS data, report prepared by Paula Hartig, July 26, 2004; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

Performance Indicator:	FY 2003 Actual	FY2004 Actual	FY2005 Target
Value:	6.1%	4.8%	5%
Numerator	64	46*	
Denominator	1,048	952	

* estimated, based on 11 months of readmission data

Value: Percentage of persons readmitted to Regional Centers within 180 days of discharge

Numerator: Readmitted within 180 days

Denominator: Number of discharges

Numerator and Denominator Data Source: AIMS data, Regional Centers
Percent of Discharges from State Regional Center inpatient units who were Readmitted within 180 days of discharge**

Performance Indicator:	FY 2003 Actual	FY2004 Actual	FY2005 Target
Value:	18.1%	Not Available	5%
Numerator	190	Not Available	
Denominator	1,048	952	

Federal Requirements / CMHS Core Performance Indicators

PPG Core Performance Indicators*	Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS EXPECTED IN 2005 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST			

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4. Client Perception of Care	Clients Reporting Positively About Outcomes	Criteria 1 and 3	Basic Table 11	Yes
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GOAL: Increase the Percent Reporting Positively About Outcomes.

OBJECTIVE: By June 30, 2005, increase the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey.

POPULATION: all consumers with valid addresses within the Magellan Behavioral Health data base who do respond to the annual Nebraska Consumer Survey.

Value: the percentage responding positively to the

Numerator: average of positive responses to the MHSIP Consumer Survey: Perceptions of Outcomes questions (21. I deal more effectively with daily problems; 22. I am better able to control my life; 23. I am better able to deal with crisis; 24. I am getting along better with my family; 25. I do better in social situation; 26. I do better in school and/or work; 27. My housing situation has improved; 28. My symptoms are not bothering me as much).

Denominator: total number of responses

Numerator and Denominator Data Source: Nebraska annual consumer survey as reported on Uniform Reporting System / Implementation Report - Table 11. Summary Profile of Client Evaluation of Care using the official MHSIP consumer survey posted on www.mhsip.org.

Adult Consumer Survey Results

Performance Indicator:	FY 2003 Actual	FY2004 Actual	FY2005 Target
Value:	71.5%	Not Available, survey underway	72%
Numerator	344		
Denominator	481		

Child/Adolsecent Consumer Survey Results

Performance Indicator:	FY 2003 Actual	FY2004 Actual	FY2005 Target
Value:	56.8%	Not Available, survey underway	57%
Numerator	21		
Denominator	37		

Data source: from Nebraska Division of Behavioral Health Services
Nebraska 2003 Uniform Reporting System
Table 11: Summary Profile of Client Evaluation of Care
FY2004 data are being collected at this time.

Federal Requirements / CMHS Core Performance Indicators

PPG Core Performance Indicators*	Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT			
7. Service Capacity	Number of Persons with SMI/SED	Criterion 2 Developmental Table 14A	No

URS Table 14A (Nebraska FY2003 Implementation Report).

Profile of Persons with SMI/SED served - This table requests counts for persons with SMI or SED using the definitions provided by the CMHS.

	Total			
	Female	Male	Not Available	Total
0-3 Years	88	134	8	230
4-12 years	339	540	0	879
13-17 years	490	562	0	1052
18-20 years	162	156	0	318
21-64 years	4,041	3688	5	7734
65-74 years	112	56	1	169
75+ years	52	35	0	87
Not Available		0	0	0
Total	5,284	5,171	14	10,469

GOAL: Number of Persons with SMI

POPULATION: Adults with serious mental illness served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services as reported within the Magellan Behavioral Health Information System

Value: Total persons with SMI or SED Served as reported on URS Table 14a

Performance Indicator:	FY2003 Actual	FY2004 Projected	FY2004 Actual	FY2005 Target
Value:	10,469	10,500		10,500

Data source: from Nebraska Division of Behavioral Health Services

NE Uniform Reporting System 2003 / Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

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SECTION II – STATE PLAN CONTEXT – Children and Families Section

A brief description of the state public mental health service system (for children and adolescents) as it is envisioned for the future

Based on data which indicates areas of need, the state has the ability to plan for a public mental health system in which all children with mental health needs have access to a comprehensive, integrated system of care that meets the following principles:

- Community based, with the focus of services as well as management and decision making responsibility resting at the community level.
- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- Provide access to a comprehensive array of effective services that address the child's physical, emotional, social, and educational needs.
- Individualized services in accordance with the unique needs and potentials of each child and guided by an individualized support plan.
- Provision of early identification and intervention in order to enhance the likelihood of positive outcomes.
- An array of services which support youth

The desired outcome for the children's public mental health system is to move from a fragmented system to an integrated system. Funding agencies, in conjunction with families, providers and communities, coordinate policy development, needs assessments, planning, service development, funding, program evaluation, utilization management, information management, and quality improvement. Families are organized to support and advocate for one another and are included at every level of decision making. Service providers are joined in a network to coordinate care and to ensure services are high quality. Communities organize resources and supports to help children and families. All youth with Serious Emotional Disturbances will receive services which enhance their ability to transition successfully into adulthood with minimal disruption in service and maximum success potential.

Children's Goal #1: Strategic Planning

The state service system as it is envisioned for the future: To implement a data based strategic planning process which supports a comprehensive service system for all children with serious emotional disturbances and their families, through early childhood to their transition to adulthood.

Previous State Plan

Services in the public system are primarily available to specific target groups, including children who are state wards, children who are involved in the legal system, and children with families with no insurance or financial resources. This gap in service exists primarily because the need is great and funding resources are limited. Therefore, funds have been targeted to provide services for very specific groups of children and their families. However, we believe it is prudent to revisit these gaps on a periodic basis to determine if services have been increased to these populations, and to make adjustment in the expansion of targeted populations based on current needs as supported by data.

The States Priorities and Plans to Meet Unmet Needs

As previously stated, Nebraska's Medicaid funding was reduced. A major part of the bill that passed eliminates Medicaid coverage for 19- and 20-year-olds who live alone and make less than \$392 a month, known as "Ribicoff" coverage. The state estimates that more than 3,100 low-income young adults statewide lost Medicaid eligibility. It is believed that these health-care costs

are going to be shifted to other systems. Also eliminated is a presumptive eligibility provision for low-income children. It is estimated that about 20 percent of children who receive services under presumptive eligibility are later determined not to be eligible for Medicaid. By eliminating the presumptive eligibility provisions, about 340 children a month will receive services. This will significantly impact children's eligibility for behavioral health service, and has potential for cost shifting to the already overburdened public behavioral health system.

Additionally, our children's systems continue to be primarily reactive in nature. Children may not be able to access mental health services until their parents have relinquished custody or they have become involved with the criminal justice system.

In FY03, the Office of Protection and Safety issued a request for proposals for provision of Multisystemic Therapy, which was to be funded by Medicaid. The target population to receive MST services included youth ages 10-20, diagnosed with a DSM-IV mental health disorder, placed out-of-home or at risk of an out-of-home placement, involved in the juvenile justice system or at-risk of committing a criminal offense, and experiencing school failure, or at-risk of dropping out or being expelled from school due to behavior problems. Unfortunately, this proposal was not carried forward as funding was not available without pulling funds away from current services. However, in FY05 plans have been resumed to fund this service through Medicaid.

However, new programs for target children continue to be developed using funds from outside the mental health system. One such funding initiative is the Violent Offender Incarceration/Truth-in-Sentencing (VOI/TIS) Federal Grant. VOI/TIS funding is offered by the federal government to assist states in addressing issues of violent offenders and overcrowding in their juvenile correctional facilities. Nebraska was awarded VOIT/TIS funding in the amount of approximately \$4 million to increase bed capacity for violent juvenile offenders and to address issues of overcrowding in the Youth Rehabilitation and Treatment Center (YRTC) in Kearney. Nebraska is required to provide a 10% match. Nebraska identified two specific services to assist the YRTC in Kearney to address their overcrowding. HHS/OJS and the facility are working to implement and operationalize these two programs at the present time. One program being established is a sexual offender program, and the other is a culturally sensitive transitional program for African-American youth. All youth referred to either of these programs will remain committed to the YRTC-K, but be served at a site other than the main campus. The alternative site programs will be self-contained and offer specialized services to meet the behavioral, emotional, and physical needs of these particular youth.

The Sexual Offender Program will be located in Lincoln and will be able to serve approximately 7-9 male juveniles. Youth in this program will have significant functional impairments due to emotional disorders, as well as cognitive and/or sexual behavioral impairments. They will have persistent patterns of disruptive behavior and disturbance in age-appropriate adaptive functioning, and be at very high risk for causing harm to self or others. Youth will receive specialized services to address their sexual offender issues and other issues impacting their daily functioning. This program was targeted for implementation last year, but has not yet been implemented. Plans continue for implementation.

The Transitional Living Program will be located in Omaha and will be able to provide culturally sensitive alternative programming for 8-10 African-American juvenile males instead of traditional programming at YRTC-Kearney. This program will concentrate on teaching these youth viable independent living skills for success in the future and to divert them from any future delinquent behaviors. Youth in this program will also have significant functional impairments due to emotional disorders and possibly have cognitive impairments. They will have persistent patterns of disruptive behaviors, disturbance in age-appropriate adaptive functioning, and be at risk for causing harm to self or others. In addition, they will receive services to improve upon their lack of vocational, interpersonal, and social skills generally considered necessary to live in the mainstream of society and be drug-free, free of criminal behavior, and legitimately successful. Offering such a culturally sensitive program will also enable the department to begin to address the issue of disproportionate minority confinement (DMC). This program was also targeted for implementation last year, but has not yet been implemented. Plans continue for implementation.

Nebraska Health and Human Services, with assistance from NASMHPD, sought technical assistance from the Bazelon Center for Mental Health Law in resolving the issue of custody relinquishment of children in order for them to access mental health services. Nebraska Federation for Families and the integrated finance committee from the two federal grant sites participated in conversation and presentations with Mary Giliberti, JD, from the Bazelon Center that explored alternative access to services for families who historically may have surrendered custody of their children to the state in order to receive Mental Health services. The proposal to explore funding for wraparound services funded by the Children's Medicaid Waiver was initiated, but again fell by the wayside in response to proposed Medicaid cuts. However, renewed interest to resurrect these efforts has been shown by Nebraska provider organizations (NABHO) and technical assistance will again be sought to accomplish implementation.

Three new wraparound programs (Integrated Care Coordination Units-see Goal 3) for state wards have been funded by the Office of Protection and Safety, and provide new opportunities for youth in the Protection and Safety system. We would like to see additional funds for the Professional Partner Program, which provides wraparound services for non-wards. In Region 3, cost savings from the ICCUs has been appropriated to prevent at risk children from becoming wards (i.e. custody relinquishment) by providing wraparound services. We hope this trend continues.

Nebraska has applied for a FY04 state infrastructure grant to support systems of care at the state level. Although some Nebraska communities have developed comprehensive, integrated systems of care that provide exceptional services for children and families, these efforts are islands of excellence in a troubled sea. The State has significant challenges in appropriately addressing the behavioral health needs of its children and their families. Vast areas of the state are frontier and rural and have severe shortages of mental health and substance abuse professionals. Of Nebraska's 93 counties, 86 are designated psychiatric shortage areas. Even when services are available, families have difficulty affording behavioral healthcare; Nebraska has seven of the 12 poorest counties in the nation. According to an Omaha World Herald expose' on children's mental health, one in four families of children with serious mental health problems were

encouraged to relinquished custody of their child just to access behavioral healthcare that they could not afford; Nebraska has the highest number of children per capita in the country who are wards of the state. Nebraska has a growing population of ethnic/racial minorities; these populations present unique behavioral health needs that the current system is ill prepared to meet. Other challenges include fragmentation across systems, lack of evidence-based services, and funding structures that are not supportive of individualized, family-centered care.

Specifically the State Infrastructure Grant application proposes to help expand wraparound across systems, develop service models for challenging populations (children ages birth through 5, transition-aged youth, and youth with co-occurring substance abuse and mental health disorders), establish culturally and linguistically appropriate practices, and create a forum for state agencies to work with stakeholders to develop an integrated, family-centered behavioral healthcare system for children and families. A wide array of stakeholders are committed to this project including the state agencies responsible for mental health, substance abuse, Medicaid, child welfare, juvenile justice, education, vocational rehabilitation, public health, and developmental disabilities. Local systems of care have also committed to the success of this project including the two SAMHSA system of care grantees (Nebraska Families Central and Families First and Foremost), the two Safe Schools, Healthy Students grantees in Omaha and Beatrice, and the Governor's early childhood mental health system of care initiative in central Nebraska. Other stakeholders committed to the project include two family organizations (NAMI-Nebraska and the Nebraska Federation of Families for Children's Mental Health), three state commissions (Nebraska Commission on Indian Affairs, Mexican American Commission, and the Crime Commission), other system of care communities such as Panhandle Partnership for Health and Human Services, provider organizations, faith organizations, University of Nebraska (Public Policy Center, Center for At-Risk Children's Services, Monroe-Meyer Institute) private foundations, and the Nebraska Legislature's Health and Human Services Committee. The need for infrastructure development identified in this application is wholly consistent with the priorities of Nebraska. Through the leadership of the Governor and the Legislature's Health and Human Services Committee, Nebraska enacted major legislation this spring designed to ensure access to behavioral health services, create an appropriate array of community-based services and a continuum of care, coordinate behavioral healthcare with primary healthcare services, develop services that are research based and consumer focused, ensure consumer involvement as a priority in all aspects of service planning and delivery, and develop funding that is fully integrated and supports a plan of treatment.

In summary, these new projects were proposed/developed to provide mental health and other supports for children and their families within targeted populations, and to change the way the state supports local efforts. Additional projects may be needed to prevent legal involvement or custody relinquishment. However, as funds are limited, new money for "preventative" services are not available at this time.

State Children's Goal 2: Family Support

State Service System as it is envisioned for the Future: The goal is to support comprehensive, community-based family peer mentoring for families of children with emotional, behavioral, and mental health issues.

- Support is child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- Services are within the least restrictive, most normative environment that is clinically appropriate.
- Families and surrogate families should be full participants in all aspects of planning and delivery of services.
- Family organizations receive support from multiple initiatives, increasing financial viability

Previous State Plan

FY03 Goal #1 To provide comprehensive, community-based family support for families of children with emotional, behavioral, and mental health issues.

The States Priorities and Plans to Meet Unmet Needs

New Projects involving the support of families include: The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services offered a proposal to solicit bids for a new support activity called "Families Mentoring & Supporting Other Families", a joint initiative to request proposals from qualified sources to provide:

- A. Strength-based, family centered, and partnership oriented supports to:
 - 1) parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or
 - 2) parent who are involved with the department as a result of a report of abuse/neglect, or
 - 3) parents whose children are diagnosed with a serious emotional disturbance and substance dependence disorders.
- B. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans and any other care plan).

The outcomes for parents served are:

1. To have support of other families that are coping with similar challenges.
2. To reduce parental feelings of emotional and social isolation that sometimes occur in parenting a child with emotional and behavioral challenges.
3. To have referral sources to access the appropriate services for their child and other family members.
4. To be equal partners in the system of care.
5. To learn how to enhance communication and networking with the professionals involved in the case.

The program objectives are to support one parent organization within each of the service areas/regions, for all individual parent organizations awarded contracts to come together and form a consortium so there is some commonality and consistency between the 6 service areas/regions organizations and an opportunity for statewide issues to be addressed. HHS has a collaborative relationship with the consortium. The consortium members may be required to

meet with HHS via telephone conference calls on a quarterly basis and in-person one-two times per year. They deliver parent to parent supports that are efficient, effective and responsive as well as tailored to the unique and individualized needs of the child and family and measure and demonstrate the parent outcomes outlined above.

All supports are community-based and provided at the local community level. Organizations must ensure supports have the capacity to address the unique culture of each family and child. Organizational supports need to recognize the importance of understanding the values, beliefs, and practices of diverse cultures. Organizations integrate diversity into their practices and products so that interactions with individual children and their families can be mindful of, and honor, the family's home culture.

One organization has been selected from each of six service areas of Health and Human Services and the corresponding mental health and substance abuse regions to develop a program that will provide supports to targeted families (1) whose children have been made state wards, (2) are involved with the department as a result of a report of abuse/neglect, or (3) whose children are diagnosed with a severe emotional disturbance and substance dependence disorders.

In addition, NAMI –Nebraska has purchased the “Visions for Tomorrow” curriculum to provide education and support to families in southeast Nebraska. Visions for Tomorrow education workshops are designed for caregivers of children and adolescents who have been diagnosed with a brain disorder as well as those who exhibit behavior that strongly suggests such a diagnosis.

- i. There is no charge for the course for the caregivers.
- ii. Visions' teachers are caregivers themselves.
- iii. The course has been designed and written by experienced caregivers, family members and professionals.
- iv. The course balances basic psycho-education and skill training with self-care, emotional support and empowerment.

Purpose is to provide basic education and knowledge of various brain disorders, to provide general information for networking with support groups and dealing with the different systems of care and

to provide basic information and methods needed to advocate for persons with brain disorders.

The project is slated to begin in September of 2004.

Although the number family support projects continue to increase, a large number of caregivers of children with disabilities, including SED, continue to live in isolation without support. A large number of grandparents are now raising their grandchildren, and a proportionate number of those children have disabilities. Providers report that they are observing a trend in the number of grandparents who are raising their grandchildren. The grandparents have reported that programs which recognize the unique needs of older adults raising children with disabilities seem to be virtually nonexistent in Nebraska.

State Children's Goal #3: Integration of Service Systems

State Service System as it is envisioned for the Future:

We will collaborate across child serving systems to provide a system of integrated services for children with serious emotional disorders who have multiple and complex needs.

- Services are integrated, with linkages among child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
- Case management ensures that multiple services are delivered in a coordinated and therapeutic manner and services and supports are adapted to the child's changing needs.

Previous State Plan

FY03 Goal #3: To provide a system of integrated services for children with serious emotional disorders who have multiple and complex needs

The States Priorities and Plans to Meet Unmet Needs

The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services under Health and Human Services have been meeting monthly for approximately the past year to collaborate on youth and family issues. The meetings provide a means for the offices to share information and collaborate on projects.

The Office of Protection and Safety, Medicaid/Managed Care, and Office of Mental Health, Substance Abuse and Addiction Services are collaboratively working to make improvements to the Office of Juvenile Services (OJS) pre-disposition residential and non-residential evaluations for delinquent youth. The offices are redesigning the OJS evaluation and components of the mental health and substance abuse models used for assessments and evaluations so that information collected on a youth can more effectively assist the court and agencies in making appropriate care, placement and treatment decisions for youth. The newly designed evaluations will be used starting in approximately October 2003.

For younger children, Nebraska Health and Human Services has submitted an application to the U.S. Maternal and Child Health Bureau for the **State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program**. Nebraska state agencies, in partnership with professional organizations, community-based providers, families, and advocates, have made significant progress in addressing various aspects of early childhood systems of care. Several initiatives have resulted in planning documents and pilot projects. A major challenge that remains is to achieve an integrated, comprehensive plan that addresses the five key components of: (1) access to health care and a medical home; (2) **mental health and socio-emotional development**; (3) early care and education/child care; (4) parent education; and (5) family support. In addition, a number of other challenges are being faced in Nebraska that impact upon the health and well-being of Nebraska's young children and their families and the system that supports early childhood programs and services. Among these are an increasingly diverse populations and large expanses of rural and sparsely populated areas. In addition, gaps exist in data availability and utilization, including an absence of agreed-upon early childhood indicators.

The goal for this proposed project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The proposed 2-year planning project will focus on processes and products that will be essential for laying the foundation for effective implementation of a strategic plan and the ultimate realization of improved outcomes for young children and their families.

Objectives include:

1. Establish a planning structure and process that engages the full spectrum of early childhood stakeholders, with an emphasis on family involvement;
2. Develop vision and mission statements and identify key outcomes for young children and the early childhood system in each of the five essential components;
3. Develop a set of indicators linked to outcomes;
4. Identify and rank priority needs and issues in each of the five essential components;
5. Develop strategies and associated action plans for each of the priority needs and issues;
6. Obtain commitments to accept and implement the strategic plan from key policy makers; and
7. Develop a comprehensive plan for sustaining the effort.

The Governor-appointed Early Childhood Interagency Coordinating Council (ECICC) will serve as the Project Advisory Committee. The ECICC has done extensive work in examining early childhood care and education issues, and its membership represents a wide range of interests, including child care providers, state agencies, parents, business, health care providers, and others. In addition, a 20 – 30 member Project Leadership Team will engage representatives of state agencies, Tribal government, provider and family associations, advocacy groups, the business community, military installations, and other important stakeholders. Eight work groups will further facilitate involvement and coordination with state-level and community-based efforts. Planning activities will actively build on earlier and existing initiatives.

The project will measure progress in achieving seven planning phase outcomes and five short-term implementation outcomes. The planning phase outcomes are: (1) linkages formed among system and community/client stakeholders; (2) planning structure and staff established and functional; (3) workgroups formed, oriented to process, and prepared to carry out assignments; (4) community/stakeholder vision and mission developed; (5) strategies consistent with vision and mission; (6) policy changes identified to drive implementation phase; and (7) public support for change enhanced. The five short-term implementation outcomes are: (1) a model for shared decision making disseminated system wide; (2) improved capacity among stakeholders in the area of policy development; (3) information and administration infrastructure in place to increase exchanges; (4) system improvement resulting from training and coaching of stakeholders; and (5) ongoing stakeholder participation and data to improve early childhood systems planning.

The goal of this project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The proposed 2-year planning project will focus on processes and products that will be essential for laying the foundation for effective implementation of a comprehensive strategic plan and the ultimate realization of improved outcomes for young children and their families. The Department of Health and Human Services has recently been notified that this project has been funded.

Source: ABSTRACT, Nebraska's Comprehensive Early Childhood Strategic Planning Project, Nebraska Department of Health and Human Services, 2003.

The ICCU is a public care coordination collaborative that includes Department of Health and Human Services Division of Protection and Safety and Region III Behavioral Health Services Care Coordinators who will ensure that care is individualized and adhere to the following wraparound principles: A no reject/eject philosophy, comprehensive assessment to determine the child and family's needs, child and family team consisting of both professionals and non-professionals who know the child and family, a Care Coordinator, with a caseload of 1:10, to facilitate the child and family team, development of an Individualized Child/Family Support Plan based on the strengths of the child and family; strategies that are individualized to the child and family's needs and based on the family's cultural background. Through flexible funding, purchase of services and supports identified in the plan are made. Use of community teams to broker informal resources to support families and monitoring of outcomes and modification of strategies to produce better results are also used.

Other important system components include family operated support and advocacy organization for families of children with serious emotional and behavioral issues, the **Care Management Team** which provides utilization management/review, a strong cross agency **Program Evaluation** component which collects demographics, service utilization, cost, and outcome data, and the **ICCU Director's** with membership consisting of key representatives of the three system partners .

The children and adolescents served share the following characteristics:

- High functional impairments in multiple areas (e.g., school, home, community, self harm, substance abuse)
- Persistent problems over long term
- Multi-agency involvement
- High service costs (although they constitute less than 25% of the state ward population in Central Nebraska, they use almost 70% of the resources).
- Poor outcomes in traditional services

SECTION III – STATE PLAN:

CHILD STATE PLAN (FIVE CRITERIA)

Criterion 1: Comprehensive Community- based Mental Health Service Systems

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services, and resources in a comprehensive system of care, including services for individuals diagnosed with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside inpatient or residential institutions to the maximum extent of their capabilities shall include:
 - Health, mental health, and rehabilitation services;

- Employment services
- Housing Services
- Educational Services
- Substance Abuse Services
- Medical and dental services
- Support services
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services; and
- Other activities leading to reduction of hospitalization.

Organized community based system of care

Regional Systems of Care

As a part of the six regional behavioral health systems in Nebraska, each Regional Youth Specialist take the lead in pursuing the development of a **comprehensive system of care for children and families** within each Region. Each system should include an array of effective services provided by highly trained staff, individualized care and coordination of services through a wraparound approach, families as equal partners at all levels, service provision and system design which is culturally competent, and an integrated service delivery system across mental health, education, child welfare, juvenile justice, and substance abuse services. This is provided through a community-state partnership. Youth specialists work to effectively manage the system to produce positive outcomes for children and families in a cost effective manner.

Available System of Treatment and Support Services Purchased

At the present time, funding sources purchasing mental health services for children and adolescents are administered through the Nebraska Health and Human Services system. The Health and Human Services is administered by three agencies (Services, Finance and Support, and Regulation and Licensure) that are coordinated through the HHSS Policy Cabinet. The Department of Health and Human Services (HHS), Division of Behavioral Health is the Mental Health Authority for Nebraska and administers state and federal mental health block grant dollars through six regional mental health/substance abuse administrations that are county operated. The HHS Division of Protection and Safety is the combined child welfare/juvenile justice authority for the State and works closely with the Behavioral Health Division and Mental Health Regions to address the needs of children and adolescents with serious emotional disorders, who are wards of the state, and their families. The Medicaid Division is within HHS-Finance and Support and coordinates with the HHS Behavioral Health Division to administer Medicaid funding for child and family mental health. An Administrative Services Organization (Magellan) assists both agencies in utilization management, claims payment, and data collection for the public (Medicaid and non-Medicaid) behavioral health system. The Nebraska Department of Education administers state and federal education funding and has collaborated with the HHS Behavioral Health Division on school-based mental health services, early childhood mental health programs and vocational services for transitioning youth.

Funding Pathways for services Currently, federal block grant and state mental health dollars are administered through Health and Human Services, Office of Mental Health, Substance Abuse

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and Addiction Services via the six behavioral health regions. The Medicaid managed care program is administered by an administrative services only contract with Magellan Behavioral Health. Child welfare/juvenile justice funding is administered through the Department's Protection and Safety Division and local Health and Human Services Offices.

Mental Health and Substance Abuse Rehabilitation Services Provided:

Public System	Medicaid EPSDT	Child Welfare/Juvenile Justice
Mental Health Treatment: <ul style="list-style-type: none">• Outpatient Therapy• School Wraparound• Professional Partner Program• Day Treatment• Home-Based Services• Therapeutic Foster Care• Respite Care•	<ul style="list-style-type: none">• Outpatient Mental Health Treatment• Treatment Crisis Intervention• Day Treatment• Treatment Foster Care• Treatment Group Home• Enhance Treatment Group Home• Residential Treatment• Inpatient Hospital Services	<ul style="list-style-type: none">• Early Care and Education• Parent Education• Family Support Groups• Home-Based Support• Intensive Family Preservation• Home-Based Therapy• Non-Home Based Therapy• Respite Care• Day Treatment• Emergency Shelter Care• Foster Care• Group Care• Community-Based Evaluation• Tracker Services• Day/Evening Reporting Programs• Proctor Care• Support/Wraparound Services• Residential Evaluation• Electronic Monitoring• Youth Rehabilitation and Treatment• CentersCase Management

Substance abuse treatment services include:

The following substance abuse services are available to children under Criteria 1 through the Nebraska Behavioral Health system.

Youth Community Support-The Community Support Program is for youth with an Axis I Substance Abuse Diagnosis or a Dual Disorder Diagnosis with a Primary Substance Abuse Disorder. Community Support is designed to assist substance abusing youth and their families to recognize substance abuse problems, and provide/develop the necessary services and supports which enable youth to live in the community with their natural family, foster parents or adoptive parents in a lifestyle free from substance abuse. The program should provide the youth with the ability to maximize quality of life in a substance free manner including participation in school and community. Community support staff will facilitate communication and coordination between multiple service providers that serve the same youth, including the school and educate

and support parents to meet the specialized needs of the substance abusing youth. Community support provides youth advocacy, ensures continuity of care, and supports youth and their families in time of crisis. Staff will provide and procure youth and parent skill training in dealing with substance abuse and related issues, ensures the acquisition of necessary resources and assist the youth in achieving community/school/ /vocational integration in a lifestyle free from substance abuse, in a developmentally appropriate manner. The community support program provides a clear locus of accountability for meeting youth and related family needs with the resources available within the community. The role of the community support worker may vary, and services are generally provided out of office in community locations consistent with individual youth need.

Youth Partial Care Partial Care Programs provide group-focused, non-residential services for substance abusing youth or dually diagnosed youth who require a more restrictive treatment environment than that provided by outpatient counseling, but do not require a residential program. Activities of this program must focus on aiding youth and their families in recognizing their substance abuse problems, and assisting youth to develop knowledge and skills necessary for making lifestyle changes necessary to maintain a life free from substance abuse. Partial care staff will work cooperatively with the schools to support successful educational performance by the youth, documenting that educational services have been maintained while in care. Adequate professional structure to prevent immediate relapse must be provided. Partial care would average, at the minimum, 30 hours per week of structured activities and may include individual, family and group counseling services.

Youth Therapeutic Community Therapeutic Community programs provide long term comprehensive residential treatment for substance abusing or dually diagnosed youth for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of substance abuse on the youth's life or because of a history of repeated short term or less restrictive treatment experiences. These programs provide psychosocial skill building through a long term, highly structured set of peer oriented treatment which define progress toward individual change and rehabilitation. Activities are developmentally appropriate for youth, and incorporate a series of defined phases. The program is staffed on a 24 hour basis, and has access to on call medical personnel. Youth educational needs may be met on site.

Youth Short Term Residential Short Term Residential programs provide highly structured (24) hour comprehensive services for substance abusing youth or dually diagnosed youth who require a more restrictive treatment environment to prevent the use of abused substances. For a youth to be eligible for services, there must be documentation from a youth assessment that shows that there is no reasonable chance of maintaining youth in their family and educational environment during treatment. Activities of this program must provide daily structure to prevent access to abused substances. The program must focus on developmentally appropriate ways to develop the knowledge and skills necessary to maintain a life free from substance abuse. Short Term Residential services must be integrated into the continuum of a youth's care to allow youth to move from a residential to a less restrictive placement. The expected duration of treatment is no more than (45) days.

Youth Halfway House Youth Halfway House programs provide transitional residential treatment services for youth seeking to re-integrate into the community, generally after short term or intermediate residential treatment. These programs must provide a structured set of activities designed to develop the independent living skills necessary to remain free from substance abuse outside a residential treatment setting. They should assist the youth to return home or to access a temporary family home environment. The program must also focus on assisting youth to maintain educational involvement.

Youth Intensive Outpatient Intensive Outpatient provides group focused, non-residential services for substance abusing youths who require a more structured treatment environment than that provided by outpatient counseling, but who do not require a residential program. Activities must focus on aiding youth to recognize their substance abuse problems and to develop knowledge and skills for making lifestyle changes necessary to maintain a life free from substance abuse. It is a non-residential, facility based, multi-service program centered around group counseling services designed to stabilize and treat youth with moderate to severe substance abuse problems. Other services could include: 24 hour crisis management, individual counseling; education about AOD issues, family education and counseling, self help group and support group orientation.

Youth Outpatient Therapy/Evaluation Outpatient therapy is a specialized substance abuse program for youth experiencing a substance abuse problem that causes moderate and/or acute disruptions in the youth's life. Outpatient programs provide individual, family, and group treatment services, generally on a regularly scheduled basis. The outpatient program provides to each youth served the appropriate assessment and/or diagnosis of the substance abuse problem, as well as effective treatment to change behaviors in order to attain and maintain a substance abuse free lifestyle. Programs may include collateral or adjunctive services. Adjunctive services are designed to link and coordinate other services necessary for the youth, in order to achieve successful outcomes. These services may include information gathering and reporting, coordination of services, referral facilitation, and related activities to assure coordination between programs.

Assessment Only Assessments are conducted by a Certified Alcohol/Drug Abuse Counselor to evaluate youth that exhibit behaviors, which may be indicative of a substance abuse problem. Such an assessment would attempt to determine if a substance problem exists, the extent of the problem, identify biopsychosocial and other contributing factors, and recommend what, if any, treatment is needed. An assessment should specify youth strengths and weaknesses, which will aid in formulating a treatment plan. Standardized screening and assessment tools may be used when conducting a substance abuse evaluation.

Description of the State's Case Management System

Children and adolescents with serious emotional disorders receive **case management** through the mental health programs that serve them. Regulations require that all mental health programs funded by the Department that serve children and adolescents have policies and procedures to ensure that families and youth with serious emotional disorders needs, are actively involved in treatment planning and have the skills necessary to support and maintain those treatment goals. Documentation on the service record must reflect the service recipient's treatment/rehabilitation needs and experience. The plan should be of the kind and quality to facilitate service planning,

evaluation, and continuity of care. Those programs determine criteria for eligibility for case management.

Medical Services may be provided through funds in the MATERNAL AND CHILD HEALTH BLOCK GRANT STATUTORY AUTHORITY: Chapter 21, Article 22, R.R.S., 1943. The administering agency is the Department of Health and Human Services/Finance and Support. Under Title V of the Social Security Act of 1935 as amended, Nebraska receives federal funding to address the health needs of all mothers and children, with particular responsibility towards low-income individuals or other populations with limited access to care. The projects provide services to low-income, high risk Group mothers and infants, to children and adolescents and to children with **chronic handicapping or disabling conditions**. The following services are provided through projects targeted for children and adolescents:

- prenatal education, home visits, health screening, direct care and follow-up to pregnant adolescents
- health screening, history, physical examinations, nutrition counseling and anticipatory guidance
- acute and chronic care
- preventative and simple intervention dental care
- mental health services
- immunizations
- access to Health Check services through Medicaid
- teen pregnancy prevention education and intervention
- nutrition education
- dental health and dental education services

Dental Services may be provided by the Dental Health Program, which provides comprehensive dental services for children who would not otherwise receive care because of economic or other reasons beyond their control. This program is funded by the Maternal and Child Health Block Grant. The Dental Health of Children Program serves school and preschool age children from low-income families who do not qualify for Medicaid. The Program serves as an entry point into the dental health delivery system for eligible children and to improve the quality of services necessary to prevent disease and restore and maintain oral health.

Project services include:

- preventative services
- examination and diagnosis
- treatment
- correction of defects
- aftercare

In Nebraska, these programs located in rural areas are structured so as to utilize the services of private dental practitioners through contractual agreement. Four community action agencies in Richardson, Nemaha, Dakota and Red Willow counties determine client eligibility and refer eligible children to one of the approximately 30 contract dentists in 10 counties. This program serves approximately 300 children a year.

Housing and other **support needs** are addressed through referral to appropriate services. For youth diagnosed with a serious emotional disturbance who are at risk of being placed out-of-home, becoming a state ward, or committing a juvenile offense, **case management** is provided through the Professional Partner Program, funded by the Office of Mental Health, Substance Abuse and Addiction Services. This program includes strength-based assessment, treatment planning, brokering services, and monitoring plan implementation.

Prevocational/Employment services for children with serious emotional disturbances are also provided through the public school system under the provision requiring **transition services**. The term transition services means a coordinated set of activities for a student with a disability that is designed within an outcome-oriented process, which promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; is based upon the individual student's needs, taking into account the student's preferences and interests; and includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation. Transition services for students with disabilities may be special education, if provided as specially designed instruction, or related services, if required to assist a student with a disability to benefit from special education.

The Workforce Investment Act is the first major reform of America's Job Training System in fifteen years. It was signed into law by President Clinton on August 7th, 1998.

Key Components include:

- Streamlining Services Programs and providers will co-locate, coordinate and integrate activities and information, creating a coherent and accessible one-Stop system for individuals and businesses.
- Empowering Individuals Individual Training Accounts (ITA's) at qualified institutions will supplement financial aid from other sources and may pay for all the costs of training. A system of consumer reports will provide key information on the performance outcomes of training and education providers. Through ITA's, participants choose training based on program outcomes. To survive in the market, training providers must make accountability for performance a top priority.
- State and Local Flexibility Significant authority is reserved for the Governor and chief local elected officials to implement an innovative and comprehensive workforce investment systems tailored to local and regional labor market needs.
- Improved Youth Programs Programs will be linked more closely to local labor market needs and community youth programs, with strong connections to academic and occupational learning.

"One-Stop" Centers serve as the cornerstone of the new Workforce Investment System. These Centers will unify training, education and employment programs into one customer-friendly

system in each community. At least one full-service center will be located in each workforce investment area. Strategic Goals for Improved Youth Programs include

Nebraska parents, educators, businesses, and service providers work as partners in providing youth with opportunities for a lifelong learning environment to reflect the changing needs and skills of the workforce. School-to-Career efforts are strengthened and expanded in order to continually invest in our youth's future by coordinating partnerships between business, students, education, and communities.

How will the youth programs be enhanced and expanded so young people have the resources and skills they need to succeed in the state's economy?

- Partnerships

Local areas will be encouraged to take advantage of the School-to-Work network and existing partnerships in their areas. Collaborative planning with the schools and School-to-Work partnerships should include: preparation of all youth for adulthood, successful careers and lifelong learning, in addition to strengthening basic skills. School-to-Work partnerships can assist local Workforce Investment boards and youth councils in providing continuity between Workforce Development and the education system.

One-Stop Services to Youth

The chief elected official, as the local grant recipient for the youth program, is a required One-Stop partner and is subject to the requirements that apply to such partners.

In addition, connections between the youth program and the One-Stop system will include those that facilitate:

1. The coordination and provision of youth activities;
2. Linkages to the job market and employers;
3. Access for eligible youth to the local youth program information and services; and (4) Other activities designed to achieve the purposes of the youth program and youth activities.

Local boards have the flexibility to offer services to area youth who are not eligible under the youth program through the One-Stop centers. However, One-Stop services for non-eligible youth must be funded by programs that are authorized to provide services to such youth. For example, basic labor exchange services under the Wagner-Peyser Act may be provided to any youth.

CORE MEASURES OF PERFORMANCE include:

YOUTH AGE 19-21

- Entry into unsubsidized employment
- 6-months retention in unsubsidized employment
- 6-months earnings received in unsubsidized employment
- Attainment of educational or occupational skills credential

YOUTH AGE 14-18

- Attainment of basic, work readiness, and/or occupational skills
- Attainment of secondary school diplomas/equivalents

Placement and retention in postsecondary education/training, or placement in military, employment, apprenticeships.

Other Transition efforts occur in cooperation with Educational Services Units in Nebraska. For example, Region 3 Youth Network Specialist attends South Central Nebraska Regional Transition Team (**ESU#9**) meetings and is an active participant. This activity continues to be ongoing. Youth Network Specialist met with the **ESU#10** Transition Services Specialist one-on-one, toured the Cozad facility, and obtained knowledge on how youth access transition services within ESU#10 service area. **ESU#11** addresses their transition services needs through the coordination of special education staff at a monthly meeting. The Youth Network Specialist had been invited as a presenter to their October 14, 2003 meeting. The transition team left further participation by the Youth Network Specialist to be on a team invitation basis. The Youth Network Specialists left business cards and Region III Behavioral Health Services brochures with the transition team members. Youth Network Specialist met with **CNSSP/GI** Transition Specialist, Cindy Hahn in August 2003 and obtained knowledge on how youth access transition services within CNSSP/GI service area. A Professional Partner continues to attend these meetings and shares those meeting minutes with the Youth Network Specialist. Last meeting attended was April 16, 2004. ESU#9 Transition Team, along with the Youth Network Specialist, participated in a strategic planning process that was led by Consultant, Dr. Robert Schalock, on April 19, 2004. A follow-up strategic planning meeting is scheduled to take place in the fall 2004. A Families CARE partner was welcomed to the Transition Team, as a new member, on January 13, 2004. ESU#9 has developed a two part survey, *The Student Exit Interview* and *The Parent's Perspective Survey*, to track youth, who have received transitional services, to assess their success and identify challenges that remain. By examining trends, patterns and developments in the data, the Team hopes for indicators of what in the education and delivery system is effective. This survey was piloted and is now be prepared for system-wide use in the fall of 2004 school year.

Alternatives to Long Term Care Efforts to further reduce the need for long term care for youth focus on the expansion of community alternatives. The Department has historically attempted to expand, and, more recently, maintain funding for needed community mental health services for children and adolescents with serious emotional disorders, including:

- Professional Partner and other middle intensity health services
- Comprehensive Community Services grants;
- Building resources around Vocational Rehabilitation/Career education opportunities for adolescents with serious emotional disturbances
- Integrated care coordination projects using wraparound for ensuring coordinated care for children in the child welfare and juvenile justice system
- Custody relinquishment in order for children to access mental health services.

Family Support Organizations Another component of the service array system in the community is the family support organizations in each of the six behavioral health regions. The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services continue to contract with family organizations for support with the initiative “**Families Mentoring & Supporting Other Families**”: Strength-based, family centered, and partnership

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oriented supports to parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or parent who are involved with the department as a result of a report of abuse/neglect, or parents whose children are diagnosed with a serious emotional disturbance and substance dependence disorders. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans and any other care plan).

The Department contracts with organizations interested in working with the State to build support services to families that will focus on providing parents with an understanding of wraparound services through peer role modeling and coaching. The philosophy of wraparound includes individualized services that are developed through professionals and parents in partnership where both are serving important roles in service delivery. Services are tailored to meet the individualized needs of the child and family and based upon strength-based assessments.

In Addition, NAMI Nebraska has purchased the training **“Visions for Tomorrow”** to provide training for families in Nebraska. The course is slated to start in September 2004. These educational workshops are designed for caregivers of children and adolescents who have been diagnosed with a brain disorder as well as those who exhibit behavior that strongly suggests such a diagnosis.

There is no charge for the course for the caregivers. Visions' teachers are caregivers themselves. The course has been designed and written by experienced caregivers, family members and professionals. The course balances basic psycho-education and skill training with self-care, emotional support and empowerment.

Purpose is to provide basic education and knowledge of various brain disorders, provide general information for networking with support groups and dealing with the different systems of care and to provide basic information and methods needed to advocate for persons with brain disorders.

Also, Nebraska Federation for Families, in conjunction with the two children's mental health grants, has worked on legislative and policy initiatives to prevent families from needing to make their children state wards in order to access services. The Department has accessed technical assistance to help them in this initiative.

GOAL #1:	Maintain capacity of Professional Partner (wraparound) program for children with serious emotional disturbance.
POPULATION:	Children and adolescents with serious emotional and behavioral disorders
OBJECTIVE:	The number of children participating in Professional Partner wraparound program will be maintained.
CRITERION:	#1 Comprehensive, community-based mental health system
BRIEF NAME:	Children enrolled in Professional Partner
INDICATOR:	The number of children participating in Professional Partner services
MEASURE:	Count of number of children participating in Professional Partners as of June 30 of each year.

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SOURCE OF INFORMATION:	Magellan Behavioral Health			
1. Performance Indicator	3. FY 2003 Actual	FY 2004 Estimated	FY 2005 Objective	% Attain
Children in Professional Partner	644	650	650	

Criterion 2: Mental Health System Data Epidemiology

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion one (1).

Regarding census data, see Adult Criteria 2.

YOUTH / Estimated Number of Children and Adolescents, **Age 9 to 17**,
with **Serious Emotional Disturbance (SED)**, 2002

	Number of Youth 9 to 17	Age 5 - 17 Percent in Poverty	State Tier for % in Poverty	Level of Functioning Score=50		Level of Functioning Score=60	
				Lower Limit	Upper Limit	Lower Limit	Upper Limit
		10.9%	Low	11,421	15,989	20,558	25,126
Nebraska	228,421						

22,842 = SED estimated

Deborah Baldwin <DBaldwin@samhsa.gov> 7/20/2004

U.S. Department of Health & Human Services

Center for Mental Health Services (CMHS)

Nebraska is engaging in a number of activities to expand service delivery to serve more children and adolescents with serious emotional and behavioral disorders including the following:

- Provide an array of services to the highest need youth in the all areas of the Protection and Safety system
- Refine a system of telehealth which will improve access to mental health care for all youth (and adults) experiencing a behavioral health emergency
- Continue to conduct point-in-time survey to analyze and target resources to better meet the mental health and substance abuse needs of state wards
- Conduct needs assessment in each mental health region identifying the services available, gaps in services, and priorities for service development

GOAL #2:	To maintain the number of persons age 0-17 receiving services through the Nebraska Behavioral Health System.
POPULATION:	Children and adolescents receiving Mental Health Services
OBJECTIVE:	The number of children receiving services will be maintained
CRITERION:	#1 Comprehensive, community-based mental health system

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BRIEF NAME:	Persons age 0-17 receiving services			
INDICATOR:	The number of children receiving services			
MEASURE:	Count of number of children receiving services			
SOURCE OF INFORMATION:	Magellan information management system			
1. Performance Indicator	3. FY 2003 Actual	FY 2004 Estimated	FY 2005 Objective	% Attain
Children receiving services	2765	2700	2800	

Magellan Behavioral Health / SED Persons Served FY2001, FY 2002 and FY2003						
	FY2001		FY2002		FY03	
	N	%	N	%	N	%
Total Children with SED served	2734		2,257		2424	2424
By Region:	2,562	100%	2,257	100%	2424	100%
Region 1	103	4.02%	66	2.92%	87	3.59%
Region 2	141	5.50%	125	5.54%	132	5.45%
Region 3	433	16.90%	332	14.71%	353	14.56%
Region 4	178	6.95%	181	8.02%	125	5.16%
Region 5	1,335	52.11%	1,231	54.54%	1252	51.65%
Region 6	350	13.66%	311	13.78%	432	17.82%
Unknown	22	0.86%	11	0.49%	43	1.77%
By Age:	2,562	100%	2,257	100%	2424	100%
Under 10	703	27.44%	647	28.67%	836	34.49%
10 – 14 years	919	35.87%	856	37.93%	760	31.35%
15 – 17 years	940	36.69%	754	33.41%	828	34.16%
By Gender:	2,562	100%	2,257	100%	2424	100%
Male	1,359	53.04%	1,171	51.88%	1412	58.25%
Female	1,198	46.76%	1,085	48.07%	1002	41.34%
Unknown	5	0.20%	1	0.09%	10	0.41%
By Race:	2,562	100%	2,257	100%	2424	100%

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White	2,213	86.38%	1,923	85.20%	1971	81.31%
Black/African American	105	4.10%	115	5.10%	166	6.85%
American Indian	71	2.77%	56	2.48%	74	3.05%
Asian/Pacific Islander	18	0.70%	11	0.49%	10	0.41%
Alaskan Native	3	0.12%	2	0.09%	4	0.17%
Other	127	4.96%	114	5.05%	129	5.32%
Unknown	25	0.98%	36	1.60%	70	2.89%
By Ethnicity	2,562	100%	2,257	100%	2424	100%
Puerto Rican	0	0.00%	2	0.09%	1	0.04%
Mexican	62	2.42%	66	2.92%	78	3.22%
Cuban	0	0.00%	0	0.00%	1	0.04%
Other Hispanic	79	3.08%	67	2.97%	67	2.76%
Not Hispanic	2,369	92.47%	2085	92.38%	2193	90.47%
Unknown	52	2.03%	37	1.64%	83	3.42%

Criterion 3: Children's Services

- Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:
 - Social services,
 - Education services, including services provided under the Individuals with Disabilities Education Act;
 - Juvenile justice services,
 - Substance abuse services, and
 - Health and mental health services
- Establishes defined geographic area for the provision of the services of such system.

State Level Departmental Systems At the state level, the Public non-Medicaid behavioral health system is administered by the Office of Mental Health, Substance Abuse and Addiction Services within the Department of Health and Human Services. Medicaid and the State Children's Health Insurance Program (Kid's Connection) is administered by the Medicaid Division of the Department of Health and Human Services Finance and Support. The child welfare and juvenile justice system is integrated and administered through the Protection and Safety Division of the Department of Health and Human Services. Education and Special Education are administered by the Department of Education.

Service Integration and Collaboration Efforts The Mental Health Office and the Protection and Safety Division worked together on areas of mutual interest. Some of these areas have

included developing parameters for systems of care, identifying behavioral health assessment devices to use in the HHS Protection & Safety System (Child Welfare/Social Services Department in Nebraska), developing integrated care coordination at the local level, developing wraparound training standards, and participating in Nebraska Family Portrait (planning effort for child welfare and juvenile justice). Collaboration with the Department of Education includes joint funding and development of school wraparound programs and a major initiative to address the mental health needs of young children and their families.

Education Services - Pursuant to the Individuals with Disabilities Act (IDEA) and Nebraska's state statutes, school districts are required to insure that all children with verified disabilities, from date of diagnosis to age 21, have available to them a free appropriate public education which includes special education and related services to meet their unique needs. The Nebraska Department of Education is responsible for establishing the standards for special education programs, reviewing programs and providing financial assistance. Children with disabilities must be verified in one or more of the following categories to receive special education: Autism, Deaf/blindness, Developmental Delay, Hearing Impairment, Mental Handicap, Multiple Disabilities, Orthopedic Impairment, Other Health Impairment, Specific Learning Disabilities, Speech-language Impairment, Traumatic Brain Injury, Visual Impairment, and Behavioral Disorder – this definition parallels the federal definition of “Seriously Emotionally Disturbed” as defined by the IDEA.

Nebraska provides services to children with disabilities from date of diagnosis through the school year in which the student reaches age 21. Participation of children below the age of 5 is voluntary on the part of the parent. Special education services are provided to all verified students with disabilities including students attending non-public schools and home schools. All providers of Special Education services are under the general supervision of the Department of Education for purposes of meeting the requirements of 92 NAC 51 (Nebraska's administrative rule containing regulations and standards for special education.)

The school districts establish policies and procedures to assure that, to the maximum extent appropriate, children with disabilities are educated with children who do not have disabilities and that special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. Each school district or approved cooperative shall assure an array of special education placement options are available. Those options shall include instruction in regular classes; supplemental services such as resource room, itinerant instruction or consultative services to be provided in conjunction with regular class placement; special classes; special schools; home instruction and instruction in hospitals and institutions. . Educational placement of each child with a verified disability:- is determined at least annually, is based on his/her individual education program or individual family service plan for infants and toddlers below age three and is as close as possible to the child's home.

Prior to verification for special education services, students and their parents will meet with teachers, administrators and other related staff to determine the student's needs and how best to

meet them. This meeting is generally referred to as a Student Assistance Team meeting. Often times, in Nebraska, the family may be accompanied by a **Professional Partner**, a professional trained in wraparound services, to assist the team in finding innovative solutions for assisting teachers to meet needs and allow students to remain in the regular classrooms. Tutoring and mentoring services are often provided to assist in these efforts. However, wraparound may include any innovative solution proposed and approved by the team and is not limited to a finite list of services. Other times, parents may be accompanied by other parents of SED children as part of the **family organization's** efforts to provide advocacy for students and their families. Students are eligible to receive supplementary aids and services and support services in the regular education classes or other education-related settings if these services are necessary to enable the child to be educated with non-disabled children.

Should the student's educational needs not be met by the above efforts, the child will be referred for a multidisciplinary team evaluation. The evaluation is conducted by a team which includes school district personnel and the child's parents. If the Multidisciplinary team determines that the child meets the eligibility criteria contained in 92 NAC 51, an Individualized Education Plan is written for the child. All children who are determined to be eligible for special education services, including children with Behavior Disorders (Seriously Emotionally Disturbed) receive special education and related services in the least restrictive environment.

Special education is specially designed instruction which is provided at no cost to the parents and meets the unique needs of a child with a verified disability. Related services are transportation and such corrective, developmental, and other supportive services as required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, parent counseling and training, and orientation and mobility services. These services are provided to the child pursuant to an Individualized Education Plan (IEP) which is developed by the IEP team including the parent of the child.

In addition to the special education and related services provided to children with disabilities under Part B of the IDEA, Nebraska also provides early intervention services to infants and toddlers with disabilities under Part C of the IDEA. One of the services available to infants and toddlers who qualify for early intervention services is services coordination. Services coordination for infants and toddlers with disabilities below age three is jointly administered by the Department of Health and Human Services and the Nebraska Department of Education.

A relatively new effort is the comprehensive plan of the Center on Behavior at the Center for At-Risk Children's Services, University of Nebraska-Lincoln, to implement and evaluate a three-tiered (i.e., universal, selected, indicated) prevention program, and to discuss the first year of implementation. Clear evidence regarding the overall and intervention specific effects of comprehensive three-tiered school-based prevention programs on children's social adjustment is critical as schools attempt to ensure that all children achieve social and academic success.

Teachers' report that they are unprepared to deal with problem behaviors exhibited by children with such and parents are concerned about problem behaviors within schools. Individual students are also affected, as the research paints a consistently bleak picture of post-school adjustment of students with emotional and behavioral (EBD) disorders.

In response to this growing concern, three-tiered behavior prevention programs have been recommended to help schools create more positive teaching and learning environments.

In general, three types of children exist in any school setting: (a) typical children not at risk of problems (80-90% of all students), (b) children at risk for developing antisocial behavior problems (5-15% of students), and (c) children who show signs of life-course persistent antisocial behavior patterns and involvement in delinquent acts (1-7%) Members of each group are candidates for differing levels of types of intervention that represent greater specificity, comprehensiveness, expense, and intensity. Universal, selected, and indicated levels of prevention are appropriate for each child group, respectively. To be maximally effective, prevention approaches must be directly linked to and coordinated with each other and the context of a school and community.

The Center on Behavior at the University of Nebraska-Lincoln is implementing and evaluating a three-tiered prevention program based on risk factor causal theory in seven local elementary schools. Each tier contains an evidence-based program: Behavior and Academic Support and Enhancement Model (BASE) at the universal level, First Step to Success at the indicated level, and Multisystemic Therapy (MST) at the indicated level. This research is designed to assess the overall and intervention specific effects of the programs on school, staff, child, and family levels.

Indicated Program: Multisystemic Therapy (MST)

The purpose of the indicated level intervention is to implement and examine the short- and long-term effects of Multisystemic Therapy on the social adjustment and academic achievement of children experiencing significant behavior problems. MST is a family- and home-based treatment that strives to change how children function in their natural settings - home, school, and the community - in ways that promote positive social behavior while decreasing antisocial behavior.

Target Population. MST is implemented with kindergarten to third grade children who are school-system identified with an emotional disturbance/behavior disorder, have a DSM-IV diagnosis, or exhibit maladaptive behavior that is judged in the clinical range on a standardized measure. It is anticipated that 30 children and families will be served in the 2002-2003 school year.

Referral to MST. Because of caseload restraint and the need for a wait-list control group, the referral process was as follows: (a) The school's principal or special education coordinator generated a list of 6 students that met the identification requirements; (b) A school representative contacted the family and informed the caregivers about the availability of MST services and determined their willingness to participate in an information meeting to learn more about MST; (c) If the family agreed, a MST therapist and university representative met with the family to solicit participation in the project and sign consent forms; and (d) Students were randomly assigned to either an immediate treatment or wait-list control group. The outcome measures are

the same as those described for the First Step to Success intervention. By providing a comprehensive, three-tiered model across multiple risk factor domains, we hope to (1) prevent problem behavior from developing, (2) reduce the number of at-risk students currently identified, and (3) change life-course persistent maladaptive behavior patterns for children exhibiting significant behavior problems. Through extensive, systematic training, implementation, and evaluation activities, we will be able to test the model regarding the overall and intervention specific effects of a three-tiered behavior prevention program.

Developmental of Local Systems of Care Public non-Medicaid behavioral health services are administered at the local level by the six mental health regions, which are county operated. Efforts to develop local systems of care focus on two Center for Mental Health Services Comprehensive Children's Grants. The Department of Health and Human Services in conjunction with the Nebraska Department of Education and Region III Mental Health Administration received a Comprehensive Community Services grant designed to establish an integrated system of care in 22 central Nebraska counties. In addition, the Department in conjunction with Region V Behavioral Health and Lancaster County have received a second grant which focuses on the developing a comprehensive system of integrated care to address the mental health needs of youth in the juvenile justice system. In each mental health region, Youth Specialists are working to achieve the following goals:

- Assessing the behavioral health needs of children and their families in the region and identifying gaps in services
- Developing and implementing strategies for development of an array of effective behavioral health and related services
- Developing strategies to ensure services are coordinated and care is individualized
- Developing strategies to ensure parents and other family members of children in services are equal partners at all levels
- Developing strategies to ensure service provision and system design are culturally competent
- Developing strategies for integration of service delivery and resources across mental health, substance abuse, child welfare, juvenile justice, and education
- Developing strategies to effectively manage care to produce positive outcomes for children and families in a cost effective manner

Integrated Care Coordination One of the key initiatives in system of care development is the Integrated Care Coordination Project. During FY 2001, the Department of Health and Human Services in partnership with Region III Behavioral Services developed a proposal to integrate care for children in the child welfare/juvenile justice system. Integrated care coordination is designed to effectively manage the care of children and families with multiple and complex needs at the local level. The initiative is designed to serve high-need children in Central Nebraska who are wards of the state. The youth are those in Agency-Based Foster Care (therapeutic foster care) and higher levels of care. Funding is through a case rate based on 95% of the cost of serving these youth during FY00. This project utilizes an integrated care coordination collaborative that includes Protection and Safety Workers (child welfare and juvenile justice system), Professional Partners (mental health and substance abuse service system), School-Based Wraparound Teams (education system), Families CARE Partners (family members partner with public system care coordinators to provide additional support and

advocacy for families served in the program), and Community Wraparound Teams (teams that identify and support a wraparound team to assist children and families in need. The team mobilizes informal supports that remain with the child and family far beyond the time formal services are discontinued).

Another Federal Grant was received in Lancaster County. Families First and Foremost, an organization that arose from a 7 million dollar federal grant to establish in Lancaster County a comprehensive system of mental health and other support services for youth with serious emotional disorders who are in or at risk of entering the juvenile justice system. Though the name F3 might be unfamiliar to you, the changes it's bringing to the community may have already improved the lives of neighbors, friends, and even own family members. F3's mission is to enhance and reshape plans of care for youths whose emotional disorders have led to criminal activity, substance abuse, and other forms of behavior problems.

What this means is that an emotionally disturbed youth who is believed, either by a parent, law enforcement, or another party, to be at risk for criminal activity, now has the benefit of a new kind of service system. The intent of this system is to organize a coordinated network to meet the complex and changing needs of these youths as they mature and their circumstances change. Whereas in the past, government agencies, private service providers and therapists have worked separately, F3 functions as the collaborative agent allowing all of these providers to network together to meet the needs of individual youths and their families.

Most importantly, F3 understands the importance and needs of families. Too often in the past, families were alienated from system procedures. F3 not only recognizes families as crucial sources of support but understands that family members have needs of their own when dealing with a child in crisis. With that in mind, various services and support groups are being developed for families as well as the juveniles in crisis. These services are wide-ranging and constantly evolving.

Lancaster County and its surrounding communities should be aware of F3 not only because it is implementing important changes in a system that affects so many of us, but because, as one of 67 cities that received this federal grant, they are in a position to lead the way for the rest of the country.

Additionally, the Region III and Lancaster County projects provided training and support to three other behavioral health regions to implement the program (as described above). In FY04, there were five Integrated Care Coordination Units across Nebraska serving 5 of the 6 behavioral health regions. Each organization works cooperatively with a local family organization and Health and Human Services to provide wraparound for children and their families who are at high risk for out of home placement.

Cultural Competence within the System of Care Nebraska Family Central is conducting strategic planning and program evaluation regarding cultural competence for the system of care.

Components that are measured include:

- Family Perception of cultural competency
- Analysis of demographics of service population as compared to the general population to examine systemic cultural biases.
- Ensure cultural competence training for providers

- Assess the cultural and demographics of providers (staff) to ensure that staff reflect the demographics of consumers

F3 is also pioneering the idea of "cultural competence," which is one of the grant's core values. Cultural competence means that the system recognizes that the way youths respond to treatment is often influenced by cultural factors. For example, a child from the Middle-East might bring different psychological and emotional issues to treatment than a youth of Asian or Latino heritage. To address those differences, F3 includes among its partners community-based agencies such as Faces of the Middle-East, Indian Center, Hispanic Center, Asian Community and Cultural Center and beyond.

This attention to detail and the shared commitment of a wide and diverse network of community stakeholders who have compassion and concern for the county's at-risk youth, makes F3 an important and truly unique program. The community should be aware of the way it is transforming juvenile rehabilitation by challenging the status quo with a spirit that embodies its motto: Some Things Do Change.

GOAL #3:	To provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs
POPULATION:	Children with serious emotional disorders who are wards of the state
OBJECTIVE:	The number of children who are in the custody of the state and who receive integrated care coordination will increase by 5%.
CRITERION:	Children's Services
BRIEF NAME:	Integrated care coordination for state wards with SED
INDICATOR:	The number of children receiving integrated care coordination
MEASURE:	Count of children receiving integrated care coordination
SOURCE OF INFORMATION:	Program evaluation reports
SIGNIFICANCE:	Emerging body of research indicates intensive case management using the wraparound approach can be effective in ensuring appropriate services and reducing expenses of using high cost services

1. Performance Indicator	FY 2003 Actual	3. FY 2004 Actual	FY 2005 Objective	% Attain
Number of wards in ICC	222	335	350	

Criterion 4: Targeted Services to Rural and Homeless Populations

- Describes states' outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals residing in rural areas.

Outreach to the Homeless Population The Department receives PATH block grant funds from the Alcohol, Drug Abuse, and Mental Health Administration of the Federal Department of Health and Human Services to provide services to individuals who are homeless and mentally ill. The Department contracts with Regions I, II, III, V and VI Governing Boards, which subcontract with mental health providers for PATH grant services. The projects provide

outreach, screening, and diagnostic treatment services, staff training, case management, support services in residential settings, referral, and other appropriate services to individuals identified as mentally ill and homeless. In addition, formal training presentations are made to staff concerning the needs of homeless emotionally disturbed persons. Case managers may facilitate the acquisition of income support, housing, and social services where feasible.

Children's mental health service providers are encouraged to collaborate with runaway and homeless shelters across the state. In fact many of the local provider networks in the Mental Health Regions have included shelters as part of the formal network. The Comprehensive Community Services Grant provides a laboratory to develop a system of outreach for runaway and homeless youth in central Nebraska. The shelter in central Nebraska is an integral part of the provider network in that region.

Rural School Based Wraparound One of the most effective efforts at serving children with serious emotional disorders in rural areas of the state has been the development of school-based wraparound. A major issue with many wraparound-planning efforts involves the intersection of the community, social service providers, and the schools. Developing a school-based support plan, as part of an overall wraparound plan is often complex due to language and system barriers between schools and other child and family team members. The wraparound approach must include improved academic performance as well as behavioral functioning for children. Rural school wraparound services are provided in Regions I, III and IV. The goals of this program are to eliminate or greatly reduce the frequency and intensity of the youth's referral behavior, empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school and neighborhood issues. The program also strives to develop a network of informal supports to help sustain the child and family when formal services are no longer needed. Finally, utilizing the wraparound approach the program hopes to reduce negative consequences for the child including out-of-home placements, juvenile justice involvement, and school failure, while enhancing positive outcomes including improved school performance and successful transition to adult living and employment.

Ensuring services to children in rural areas There are six counties in Nebraska designated as "Metropolitan Statistical Areas" by the U.S. Census Bureau. Using the Census Population as of April 1, 2000 for these "Metropolitan Statistical Areas", the Nebraska portion of the "Omaha, NE--IA MSA" includes Cass County (24,334), Douglas County (463,585), Sarpy County (122,595), and Washington County (18,780); the Lincoln, NE MSA contains Lancaster County (250,291); and the Nebraska portion of the Sioux City, IA--NE MSA is Dakota County (20,253). In April 2000, these six "Metropolitan Statistical Areas" counties had 899,838 people, accounting for 52.6% of the State of Nebraska population (1,711,263).

Numerator = At time of admission, Total Children with Serious Emotional Disorders Who Received Community Mental Health Services with a "County of Residence" (Magellan field # 15) outside of Douglas, Lancaster, Sarpy, Washington, Cass, and Dakota counties.

- exclude: Cass County, Douglas County, Sarpy County, Washington County, Lancaster County and Dakota County.
- include: 87 remaining Nebraska counties.

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Data source: from Magellan Behavioral Health Information System, as under contract with NE HHS/ Office of Mental Health, Substance Abuse, and Addiction Services.

GOAL #4: To maintain services to all children with serious emotional disorders in non-Metropolitan areas.
POPULATION: Children with serious emotional disorders living in non-Metro areas
OBJECTIVE: The number of children in non Metropolitan areas receiving services will increase.
CRITERION: Targeted Services to Rural and Homeless Populations
BRIEF NAME: Non Metropolitan children
INDICATOR: Number of non-Metropolitan children with serious emotional disorders receiving services
MEASURE: Count of Non-Metropolitan children receiving services
SOURCE OF INFORMATION: Magellan Behavioral Health Information System, as under contract with NE HHS/ Office of Mental Health, Substance Abuse, and Addiction Services.
SIGNIFICANCE: Assuring access to services for children with serious emotional disorders is a primary goal of the mental health block grant law.

1. Performance Indicator	2. FY 2003 Actual	3. FY 2004 Estimated	FY 2005 Objective	% Attain
Number of children in non-Metropolitan areas receiving services	1264	1300	1300	

Criterion 5: Management Systems

- Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan
- Provides for training of providers of emergency health services regarding mental health
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved

Current Mental Health and Substance Abuse (State & Federal Block Grant) Funding

State mental health and Federal Block Grant funds are administered through the Department of Health and Human Services Office of Mental Health, Substance Abuse and Addiction Services and are used primarily to fund services for persons who are not Medicaid eligible or to fund services not covered by Medicaid. These services include the Professional Partner Program, outpatient treatment, school wraparound (formerly called therapeutic consultation), respite care, day treatment, and home-based services.

Training of Providers of Emergency Health Services

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See the adult Criteria 5 for information regarding training of providers of emergency health services regarding mental health.

Description of the manner in which the State intends to expend the grant

The description of how the state intends to expend the Community Mental Health Block Grant for children and youth is contained in **Section 3 “Fiscal Planning Assumptions” for the details on children’s** allocation for FY2004.

Innovative Services. A number of innovative services have been funded through federal block grant funds. These include the Professional Partner Program, and middle intensity services like day treatment and school wraparound.

GOAL: At least maintain the Per Capita State Expenditures for Community Mental Health Services

OBJECTIVE: By June 30, 2004, there will be at least the same level of spending in per capita state expenditures for children’s community mental health services at \$8.82.

POPULATION: Total children’s population ages 0-17 years.

Per Capita State Expenditures for Community Mental Health Services

Numerator = Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)

Data source: Office of Mental Health, Substance Abuse and Addiction Services

Denominator = per Capita ...Total children’s population ages 0-17 years (450, 242)

Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001 <<http://info.neded.org/stathand/bsect8.htm> >.

Performance Indicator: (1)	FY 2003 Actual (2)	FY2004 Actual/Estimated (3)	FY2005 Estimated (4)
Value:	\$8.60	\$9.62	\$9.62
Numerator	\$3,872,010	\$4,332,646	\$4,332,646
Denominator	450,242	450,242	450,242

ATTACHMENTS

Federal Funding Agreements, Certifications and Assurances

**FEDERAL FUNDING AGREEMENTS, CERTIFICATIONS, ASSURANCES, &
REQUIREMENTS**

- Funding Agreements
- Certifications
- Disclosure of Lobbying Activities
- Assurances

Attachment A

**COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING
AGREEMENTS**

FISCAL YEAR 2005

I hereby certify that the **State of Nebraska** agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State¹ will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2005, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

1. The term State shall hereafter be understood to include Territories.

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

- (A) the principle State agencies with respect to:
 - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
 - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

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(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

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- (b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]
- (c) The State will:
 - (1) make copies of the reports and audits described in this section available for public inspection within the State; and
 - (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

- (a) The State will:
 - (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
 - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
 - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
 - (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section
- (b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Governor

Date

Attachment B: Certifications
Attachment C: Assurances